



NHPCO'S Standards of Practice

2022 Edition



NHPCO

Leading Person-Centered Care

NHPCO.ORG

NHPCO'S Standards of Practice

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NHPCO'S Standards of Practice

The National Hospice and Palliative Care Organization's (NHPCO) standards of practice encompass 10 key components of quality that offer hospice providers a clear framework for a 360-degree surveillance of their entire operation, focusing on both clinical and non-clinical areas. The standards of practice aim to assist hospice providers in meeting the Medicare Hospice Conditions of Participation (CoPs) which, among other provisions, require Medicare-certified providers to implement and maintain a Quality Assurance and Performance Improvement (QAPI) process for their organization. Hospice providers, who choose to adopt standards of practice beyond compliance regulations, measurably demonstrate organizational excellence and improvement efforts across all areas of hospice operations.

The significant value of this document lies in the effect it can have on the evolution and advancement of each organization's hospice services. It is intended to be used as an active, practical tool for reference, self-assessment, and enhancement activities. We invite you to apply the principles and standards for evaluation and continuous improvement in your organization.

The Standards of Practice for Hospice Programs are organized around the following core components, which provide a framework for developing and implementing QAPI. NHPCO is committed to ensuring our members have the tools and resources that ultimately result in improving care of patients and their families.

- **Patient and Family-Centered Care:** Providing care and services that are responsive to the needs and exceed the expectations of those we serve.
- **Ethical Behavior and Consumer Rights:** Upholding high standards of ethical conduct and advocating for the rights of patients and their family caregivers.
- **Clinical Excellence and Safety:** Ensuring clinical excellence and promoting safety through standards of practice.
- **Inclusion and Access:** Promoting inclusiveness in our community by ensuring all people — regardless of age, race, ethnicity, color, religion, gender, gender expression, gender identity, genetic information, disability, sexual orientation, veteran status, disease or other characteristics — have access to our programs and services.
- **Organizational Excellence:** Building a culture of quality and accountability within our organization that values collaboration and communication and ensures ethical business practices.
- **Workforce Excellence:** Fostering a collaborative, interdisciplinary environment that promotes inclusion, individual accountability, and workforce excellence through professional development, training, and support to all staff and volunteers.
- **Compliance with Laws and Regulations:** Ensuring compliance with applicable laws, regulations, and professional standards of practice, and implementing systems and processes that prevent fraud and abuse.
- **Stewardship and Accountability:** Developing a qualified and diverse governance structure and senior leadership who share the responsibilities of fiscal and managerial oversight.
- **Performance Measurement:** Collecting, analyzing, and actively using performance measurement data to foster quality assessment and performance improvement in all areas of care and services.

How to Use the Standards

The National Hospice and Palliative Care Organization's (NHPCO) Standards of Practice for Hospice Programs is organized into nine (9) chapters. None of the chapters are meant to stand alone. Each chapter begins with one or more principles of hospice care supporting that component of quality. Following the principle(s), the defined standards are divided into numerical group designations. The primary standard is designated by a whole number (e.g., 1, 2, 3) and is followed by related standards designated by the same whole number, a decimal and a second number (e.g., 2.1, 2.2, 2.3). The numeric designations are solely for reference and are not intended to reflect priority or importance.

Following each group of standards is a set of "Practice Examples." Practice Examples are meant to be examples of various ways to implement the standards. The Practice Examples are not intended to be requirements or descriptions of the best or only way to meet the standards. They are only intended as examples from practice that can be imitated or used to spur ideas and creativity.

At the end of the standards text are appendices. Since the principles and standards in all chapters apply to the provision of hospice care in all settings, the appendices contain only additional principles and standards relevant to a particular practice area. Standards Change Tables follow the appendices to facilitate easy identification of key changes between the 2018 and 2022 standards. We also include Glossary as a resource in this update.

NHPCO's Quality Connections Program

NHPCO is committed to assisting hospice and palliative care providers in continuous quality and performance improvement that supports safe, effective, and timely care outcomes for patients and families. Providers who actively engage in quality improvement raise the bar for performance which leads to service excellence.

Quality Connections (QC) is a national program designed to support the delivery of high-quality, person-centered care by hospice and palliative care providers. The goal of the QC program is to help hospice and palliative care programs achieve and sustain continuous quality improvement by enhancing the knowledge base, skills, and competency of staff through education, tools, resources, and opportunities for engagement and interaction. QC participants are required to achieve milestones within defined timeframes by participating in training and competency building, applying their education, measuring performance, and innovating to promote high quality care delivery.

The QC program contains four pillars: education, application, measurement, and innovation. Each pillar contains activities that contribute to continuous quality improvement. An organization must complete a minimum of four activities within a pillar over the year to achieve national recognition for their commitment to continuous quality improvement. The Hospice Quality Certificate Program, BitesizeQI, Project ECHO, online courses, and diversity and inclusion activities are a few examples of the content and tools available through the QC program.

Integrating quality improvement into all aspects of hospice and palliative care is key to achieving sustainability, as partners, payers, and consumers are looking for value and a demonstrated commitment to quality. QC helps you get there by:

- Providing the education, resources, and benchmarking tools you need to meet and exceed quality measure requirements;
- Saving you money on external performance improvement products and services;
- Giving you national recognition from NHPCO as a Quality Connections participant; and
- Demonstrating your commitment to high quality care.



Characteristics of High-Performing
Hospice Organizations

Characteristics of High-Performing Hospice Organizations

NHPCO is committed to assisting hospice and palliative care providers in continuous Quality Assurance and Performance Improvement (QAPI) activities that support safe, effective, and timely care outcomes for patients and their families. Providers who actively engage in continuous quality improvement raise the bar for performance, leading to service excellence.

There is a natural overlap of regulatory compliance and quality in hospice. On the regulatory side, compliance is required to maintain Medicare certification. Regarding quality of care, providers utilize evidenced-based practices and standards of care to provide high-performing care and services to patients and their families. The intersection of the two has a targeted outcome of excellent patient and family care throughout the hospice experience. All hospice providers must be committed to delivering the highest-quality, person-and family-centered care to not only meet but exceed federal guidelines.

This document aims to assist hospices in developing a foundational culture of quality and provides suggested operations and clinical targets (see category tables) to achieve high performance, quality of care, and service excellence.

Organizational Culture

Hospice organizations that develop a culture of quality commit to integrating continuous quality improvement throughout the organization as exemplified in their daily operations. This type of culture can only be successful when organizational leadership recognizes the quality value proposition and devotes resources to support continuous self-assessment and improvement.

Quality-driven organizations are focused on providing exceptional customer service and person- and family-centered care, recognizing the inherent opportunities for quality innovation. These organizations have chosen to exceed the federal and state regulatory requirements by utilizing standards of practice (NHPCO or accreditation organization (AO)) and providing exceptional, evidence-based care to patients and their families. Further, these organizations have a formal and comprehensive compliance program that engages staff and the governing board. These organizations participate as a member of a national and/or state professional organization (e.g., NHPCO and the state hospice organization) to ensure access to current compliance, quality, and education resources.

High-performing organizations adopt and implement quality standards to achieve operational and clinical excellence. These organizations are accountable, adaptable, and operate within an ethical code to ensure high quality, culturally competent care provision to patients and their families (See [NHPCO Code of Ethics](#) and [Guide to Organizational Ethics in Hospice Care](#)). These organizations choose to do business with other entities who share and exhibit compatible quality standards, ethics, and values that hold them accountable to meet value-driven benchmarks. While engaging in continuous quality improvement, these organizations consciously identify and understand the limitations of their programs and only care for individuals when high-quality customer service and person- and family-centered care can be provided. Furnishing safe patient care is hardwired into their culture. Every patient/family interaction ensures the patient is as protected as possible from safety issues that may occur during a serious illness. Commitment to safe patient care is reflected in strategic organizational goals and resource allocation.

Operational and Clinical Targets for High Performance

The following category tables outline targeted operational and clinical categories, characteristics, and measure for high-performing hospice organizations. The category content is cross-walked with NHPCO's [Standards of Hospice Practice](#) domains and our [Quality Connections Program](#).

NHPCO's Standards are organized around the core quality components of hospice care, which provide a framework or domains for developing and implementing QAPI.

NHPCO's Quality Connections is a national program designed to support hospice and palliative care provider delivery of high-quality, person centered care. The program goals are to enhance the knowledge base, skills, and competency of hospice and palliative care staff through education, tools, resources, and opportunities for engagement and interaction among hospice and palliative care quality professionals. The four pillars that form the structure of the program include: Education, Application, Measurement, and Innovation. Each pillar includes quality activities that drive quality movement forward.

Category: Compliance

| NHPCO Resources | Characteristics | Evidence (Demonstration of the Characteristic(s)) |
|--|---|--|
| Demonstrates an overarching commitment to regulatory compliance through: | | |
| Standards Domain: <ul style="list-style-type: none"> ■ Compliance with Laws and Regulations (CLR) Quality Connections Pillar(s): <ul style="list-style-type: none"> ■ Education ■ Application ■ Measurement | Established, structured, and relevant compliance program | <ul style="list-style-type: none"> ■ Development and implementation of a balanced compliance/quality organizational culture ■ Designated compliance staff and committee <ul style="list-style-type: none"> • Integration of compliance accountability in staff position descriptions and performance evaluations ■ Development and implementation of a continuous compliance assessment plan ■ Education provided for all staff regarding federal and state regulatory requirements ■ Compliance professional directly reports to governing board |
| | Organizational compliance with all requirements in federal/state hospice regulations | <ul style="list-style-type: none"> ■ Commitment to meeting federal and state hospice compliance requirements ■ Medicare certification/recertification survey outcomes ■ State licensure survey outcomes (as applicable) ■ Inclusion of staff in survey preparation, process, and plans of correction |
| | Coordinated compliance with community partners | <ul style="list-style-type: none"> ■ Education about community partner compliance requirements provided to appropriate hospice staff (e.g., nursing facility federal and state regulations) ■ Engagement with community partners to ensure compliance and enhance performance as needed |

Category: Quality

| NHPCO Resources | Characteristics | Evidence (Demonstration of the Characteristic(s)) |
|---|---|---|
| Demonstrates an overarching commitment to quality improvement through: | | |
| <p>Standards Domain:</p> <ul style="list-style-type: none"> ■ Performance Measurement (PM) <p>Quality Connections Pillar(s):</p> <ul style="list-style-type: none"> ■ Education ■ Application ■ Measurement | <p>Established, structured, and relevant QAPI program</p> <hr/> <p>Compliance with standards of hospice/palliative care practice</p> <hr/> <p>Submission of federal hospice quality measure data</p> | <ul style="list-style-type: none"> ■ Development and implementation of a balanced compliance/quality organizational culture ■ Collection and utilization of data drives performance improvement ■ Designated quality staff and committee <ul style="list-style-type: none"> • Integration of quality improvement accountability in staff position descriptions and performance evaluations ■ Development and implementation of a continuous quality assessment plan ■ Education provided for all staff about organizational and clinical quality improvement projects and targets ■ Organization participates in NHPCO's Quality Connections program <hr/> <ul style="list-style-type: none"> ■ Utilization of NHPCO's Standards for Hospice Practice ■ Accredited by a CMS approved AO <hr/> <ul style="list-style-type: none"> ■ Integration of federal hospice quality measure data in organizational QAPI plan and performance improvement |

Category: Staffing

A quality-focused organizational culture values its staff; engages and challenges them to collaborate within the organization to meet its mission and vision. It continuously works to foster trust between the staff and the organization by developing and supporting an environment directed towards joint responsibility for quality outcomes in the spirit of performance improvement. This organization has an excellent employer reputation in the community, good staff retention and low turnover rates because it is committed to staff involvement and cultivation.

| NHPCO Resources | Characteristics | Evidence (Demonstration of the Characteristic(s)) |
|---|---|---|
| Demonstrates an overarching investment in staff through: | | |
| <p>Standards Domain:</p> <ul style="list-style-type: none"> ■ Workforce Excellence (WE) ■ Organizational Excellence (OE) <p>Quality Connections Pillar(s):</p> <ul style="list-style-type: none"> ■ Application ■ Measurement ■ Innovation | <p>Recognition that staff are the most critical resource (e.g., has an advocacy process to ensure staff needs are met and concerns are addressed in a timely manner)</p> <hr/> <p>Bereavement support is provided for staff</p> | <ul style="list-style-type: none"> ■ Competitive salary and benefit packages are offered and regularly evaluated ■ Active staff recruitment and retention strategy is established ■ Staff engagement or satisfaction survey is conducted with all staff on a regular basis (e.g., salary and/or satisfaction – NHPCO STAR survey or like survey) ■ Encourages staff engagement by providing opportunities for feedback, open communication between staff and leaders ■ Provides a culture of autonomy, mutual respect, offer proactive guidance, encouraging staff to take responsibility for their own professional growth ■ Uses national benchmarking to determine staffing while also using agency-specific data to "personalize" staffing ratios (See: NHPCO's Staffing Guidelines) ■ Opportunities available for staff to engage in organizational activity (e.g., QAPI committee) ■ Provides flexible and innovative staffing such as self-scheduling, shared job positions, etc. <hr/> <ul style="list-style-type: none"> ■ Provides a venue to support staff with their job-related grief and stress (e.g., EAP program, support groups, and individual support available to all staff members) |

Category: Education/Professional Development

| NHPCO Resources | Characteristics | Evidence (Demonstration of the Characteristic(s)) |
|--|--|---|
| Demonstrates an overarching investment in staff through: | | |
| <p>Standards</p> <p>Domain:</p> <ul style="list-style-type: none"> ■ Workforce Excellence (WE) ■ Organizational Excellence (OE) ■ Clinical Excellence and Safety (CES) <p>Quality Connections</p> <p>Pillar(s):</p> <ul style="list-style-type: none"> ■ Education ■ Application ■ Measurement | <p>Development/ implementation of a comprehensive orientation and preceptor program</p> | <ul style="list-style-type: none"> ■ Establish a tailored orientation program to meet the needs and skill sets for new staff <ul style="list-style-type: none"> • Measurement process in place to ensure development of an individualized learning plan • Program evaluation obtained from new staff member ■ Skill validation – at hire and annually (e.g., regular skills competency evaluation) ■ Establish a preceptor/clinical ladder program <ul style="list-style-type: none"> • Measurement process in place to ensure program completion and staff competency • New staff mentoring process in place post orientation • Program evaluation obtained from new staff member ■ Assurance that staff have educational resources they need to deliver safe and competent care (e.g., in-person, didactic, tailored to specific learning needs) ■ Staff education includes diversity, equity, and inclusion (DEI) and cultural competence training and evaluation ■ Personnel records are maintained and preceptor options assigned |
| | <p>Development of continuing education program</p> | <ul style="list-style-type: none"> ■ Conducts a staff learning needs assessment annually and as needed ■ Provides federal and state regulatory and accreditation standards education ■ Provides education based on learning assessment and QAPI outcomes ■ Provides education related to specialty programs (e.g., Veterans, dementia) ■ Individualized education is based on needs and diversity of community served ■ Records are kept in personnel records of continuing education completed by all staff, including volunteers |
| | <p>Focused development and maintenance of staff competency levels</p> | <ul style="list-style-type: none"> ■ Recognizes and supports staff with specialty skill training (e.g., wound care, trauma informed care, pediatrics) ■ Obtains feedback from staff related to specific skill needs (at least annually) ■ Ensures staff have educational resources they need to deliver safe and competent care (e.g., in-person, didactic, tailored to specific learning needs) ■ Provides staff skill validation and ongoing cultivation ■ Establishes ongoing staff mentoring program |
| | <p>Encouragement and support for staff achievement of professional certifications</p> | <ul style="list-style-type: none"> ■ Provides support to staff to achieve and maintain professional certification (e.g., hospice and palliative care, quality, compliance, etc.) <ul style="list-style-type: none"> • Provides education and educational benefits to staff |

Category: Patient*/Family** Care Provision and Outcomes

| NHPCO Resources | Characteristics | Evidence (Demonstration of the Characteristic(s)) |
|---|--|--|
| Demonstrates a person-centered interdisciplinary care model through: | | |
| <p>Standards Domain:</p> <ul style="list-style-type: none"> ■ Patient and Family/ caregiver-Centered Care (PFC) ■ Clinical Excellence and Safety (CES) ■ Inclusion and Access (IA) ■ Organizational Excellence (OE) ■ Ethical Behavior and Consumer Rights (EBR) <p>Quality Connections Pillar(s):</p> <ul style="list-style-type: none"> ■ Education ■ Application ■ Measurement ■ Innovation | <p>Timely response to a hospice referral and timely/flexible admission per patient needs and wishes</p> | <ul style="list-style-type: none"> ■ Establishes a policy that ensures a timely response with consideration of individual patient/family wishes <ul style="list-style-type: none"> • Process established for triaging patient acuity for prioritization of urgent admission ■ Establishes process to identify and address barriers to timely response ■ Establishes a process for accommodating a timely admission to meet the needs of patient/family |
| | <p>Individualized proactive patient care provided by a skilled interdisciplinary team</p> | <ul style="list-style-type: none"> ■ The Interdisciplinary Group (IDG) meets patients/families where they are and honors cultural norms and communication needs (e.g., health literacy level, cultural diversity) <ul style="list-style-type: none"> • Patient/family needs are anticipated and met (e.g., visit frequency meets needs of patients/family) ■ Provides effective and timely symptom management ■ Aims to provide care that prevents unnecessary emergency department (ED)/hospitalizations |
| | <p>IDG collaboration</p> | <ul style="list-style-type: none"> ■ Collaboration is proactive and goal oriented ■ Patient plan of care goals are continuously assessed and adjusted for measurable achievement ■ Patient and family expectations and goals are acknowledged by the IDG ■ Facilitates coordination, communication, and collaboration with non-hospice staff when patient resides in a facility (e.g., skilled nursing facility (SNF), nursing facility (NF), or assisted living facility (ALF)) |
| | <p>Increased IDG presence in last days of life per patient family wishes</p> | <ul style="list-style-type: none"> ■ Provides individualized patient/family/caregiver education (e.g., what to expect, in a manner they understand (language, literacy, health literacy)) ■ Physical, emotional, and spiritual care needs are met per patient/family wishes (e.g., symptoms are controlled, patient appears calm and peaceful, etc.) |
| | <p>Organizational ability to address ethical concerns</p> | <ul style="list-style-type: none"> ■ Access is available to an internal ethics committee or outside ethics resource ■ Annual training related to ethical issues is provided to staff ■ Policy and procedures are developed for ethical consults as needed ■ Outcomes are funneled into QAPI program as necessary |

| NHPCO Resources | Characteristics | Evidence (Demonstration of the Characteristic(s)) |
|---|--|---|
| Demonstrates a person-centered interdisciplinary care model through: | | |
| | <p>Attention to patient and caregiver satisfaction</p> | <ul style="list-style-type: none"> ■ Patient satisfaction – patient needs and goals are met and feedback is documented in clinical record ■ Caregiver satisfaction – measured by Consumer Assessment of Healthcare Providers and Systems (CAHPS) or other similar satisfaction survey <ul style="list-style-type: none"> • Organization Hospice CAHPS scores are above national Hospice CAHPS (or similar survey) scores • Positive feedback from caregivers (e.g., letters of appreciation, bereavement program feedback, mission moments) ■ Positive community recognition ■ Robust patient/family education resources available |
| | <p>Provision of emotional and spiritual support</p> | <ul style="list-style-type: none"> ■ Measured by CAHPS or other like satisfaction survey <ul style="list-style-type: none"> • Organization Hospice CAHPS scores are at/above national Hospice CAHPS (or like survey) scores ■ Meeting measurable emotional and spiritual goals on a plan of care (POC) ■ Support is holistic to meet patient/family emotional and spiritual needs (spiritual – fulfillment beyond religion) (e.g., music therapy, aroma therapy, life review, etc.) ■ Utilizes NHPCO's Inclusion and Access Toolkit |
| | <p>Strong comprehensive bereavement program</p> <ul style="list-style-type: none"> ■ Proactively planning for family support post patient death (minimally 13 months after patient death) ■ Provides or connects family to community-based bereavement/specialty services | <ul style="list-style-type: none"> ■ Utilizes NHPCO's Evaluation of Grief Support Services (EGSS) survey ■ Provides individualized bereavement support to family, community, and community partners <ul style="list-style-type: none"> • Offers periodic outreach through the first year of loss • Offers 1:1 support • Provides memorial services and bereavement camps to community • Provides or connects family to community-based bereavement services • Facilitates bereavement camps • Facilitates bereavement support groups/individualized counseling in various mediums • Facilitates specialty bereavement support groups (e.g., pediatrics, acute loss, community reengagement, etc.) • Cultivates volunteer engagement in bereavement support program |

| NHPCO Resources | Characteristics | Evidence (Demonstration of the Characteristic(s)) |
|---|--|--|
| Demonstrates a person-centered interdisciplinary care model through: | | |
| | Robust volunteer program | <ul style="list-style-type: none"> ■ Maintains diverse skill set of volunteers to meet needs of patient/family and organization ■ Implements and monitors performance improvements based on metrics for timeliness of volunteer assignment, frequency of visits, and utilization among all patients/families ■ Develops specialty programs facilitated by volunteers such as: <ul style="list-style-type: none"> • 11th Hour programs • Pet Peace of Mind • End-of-Life EOL Doula • Program to honor/remember patients • Companion visitor • Music enrichment ■ Implements NHPCO's We Honor Veterans program and works to achieve level 5 partnership status ■ Utilizes NHPCO's Inclusion and Access Toolkit |
| | Complementary therapy program (volunteer or paid) | <ul style="list-style-type: none"> ■ Implementation of specialty services may include but are not limited to: <ul style="list-style-type: none"> • Music therapy • Aroma therapy • Massage/Reiki • Pet therapy • Art therapy • Play therapy (pediatrics) • Life review |
| | DEI prioritization | <ul style="list-style-type: none"> ■ Integrates diversity training in staff orientation and continuing education ■ Targets marketing about hospice care to diverse populations in the community ■ Develops hospice educational materials for diverse populations in the community ■ Targets staff hiring to meet needs of diverse populations in the community ■ Utilizes NHPCO's Inclusion and Access Toolkit |
| | Staff caseloads adjusted for patient acuity status, time required to implement patient/family plan of care (POC) interventions and staff and patient safety issues to ensure quality practice | <ul style="list-style-type: none"> ■ Utilizes staff guidelines/caseload models (or other tools) and patient acuity to determine patient caseloads ■ Builds into staffing models balanced staff support services (e.g., Licensed practical nurses (LPNs), pharmacists, admission registered nurses (RNs), and triage RNs) |

| NHPCO Resources | Characteristics | Evidence (Demonstration of the Characteristic(s)) |
|---|--|--|
| Demonstrates a person-centered interdisciplinary care model through: | | |
| | Flexibility related to patient-family needs | <ul style="list-style-type: none"> Identifies issues in IDG meetings and accommodates staffing related to the issue (i.e., two hospice aides for a difficult to move patient) Commitment to staffing four levels of care outlined in the Medicare hospice benefit (e.g., staffing for continuous homecare) Staff assignments promote continuity of care Standardized visit process |
| | Reasonable productivity expectations and effective use of resources | <ul style="list-style-type: none"> Utilization of staffing guidelines/caseload models (or other tools) and patient acuity to determine patient caseloads |
| | Consistency related to limitations of the organization | <ul style="list-style-type: none"> Policies/procedures established for staff shortage during emergency events, exceptional circumstances, or inadequate skill sets/competency of staff Referral sent to another hospice provider when quality of care standard may not be met, or patient/family have specific needs that may not be met by the hospice |
| | Structured for responsive 24/7 patient/family services | <ul style="list-style-type: none"> Staffing meets needs of patients/families on all days of the week and at any time |

*Family = individual(s) as defined and determined by the hospice patient

**Caregiver = individual(s) (paid or unpaid) providing care to the patient

Category: Community Engagement

Hospice providers who take the quality-focused route also have a strong presence in their community. They recognize the unique characteristics and diversity of their community and strive to provide culturally competent care that is equitable and meets specific needs of individuals and their families.

| NHPCO Resources | Characteristics | Evidence (Demonstration of the Characteristic(s)) |
|--|---|---|
| Demonstrates engagement in their community through: | | |
| Standards Domain: <ul style="list-style-type: none"> Inclusion and Access (IA) Ethical Behavior and Consumer Rights (EBR) Organizational Excellence (OE) | Establishes a presence in the community | <ul style="list-style-type: none"> Participates in coalitions, community work groups or programs, organization boards, faith-based organizations, emergency preparedness entities (i.e., state Emergency Management organization), community-based education and events, bereavement crisis support |
| | Assesses and develops plan to meet identified gaps | <ul style="list-style-type: none"> Completes an initial and periodic needs assessment and/or participates in external community needs assessment (i.e., evaluates needs of underserved populations – who, where, etc.) Develops and maintains relationships with other community providers, referral sources, etc. (e.g., educating physician practice related to patient timely referral to hospice) Identifies needs and requirements of community partners (e.g., SNF, NF, ALF regulations) |

| NHPCO Resources | Characteristics | Evidence (Demonstration of the Characteristic(s)) |
|---|--|--|
| Demonstrates engagement in their community through: | | |
| <p>Quality Connections Pillar(s):</p> <ul style="list-style-type: none"> ■ Application ■ Measurement ■ Innovation | <p>Engages with the community to meet needs</p> | <ul style="list-style-type: none"> ■ Establishes a Professional Advisory Committee (PAC) ■ Demonstrates flexibility to meet emergency management needs (e.g., COVID-19 public health emergency or other disasters) ■ Provides memorial services and bereavement camps to community ■ Provides or connects family to community-based bereavement services ■ Provides community education based on needs assessment (e.g., advance care planning, hospice care) ■ Expands access to underserved populations ■ Provides specialty services to Veterans ■ Provides opportunities for student or other professional internships ■ Provides caregiving education to community ■ Provides a program for teen volunteer opportunities ■ Provides fundraising activities in the community (e.g., golf tournament) ■ Identifies diverse populations in the community and strives to meet their needs ■ Utilizes NHPCO Inclusion and Access Toolkit ■ Implementation of DEI program |
| | <p>Evaluating the impact of community engagement strategies</p> | <ul style="list-style-type: none"> ■ Measures participation in community events (e.g., evaluation surveys per event) ■ Evaluates timeliness/appropriateness of patient referrals to hospice from referral source ■ Evaluates referral satisfaction |

This document was developed by a cohort of the NHPCO Quality & Standards Committee in 2021.



Patient and Family-Centered
Care (PFC)

Patient and Family-Centered Care (PFC)

Principles

- Providing care and services focused on the dying person and the grieving family's unique experience.
- The hospice unit of care is comprised of the patient, family, caregiver, and other individuals identified by the patient.
- The hospice interdisciplinary team – in partnership with the patient, family, caregiver, and other individuals identified by the patient – develops, coordinates, and carries out a care-directed, individualized, and safe plan of palliative care.
- Addressing grief and bereavement needs begins at the time of patient admission to the hospice with the initial comprehensive assessment and continues throughout the 13-month period following patient's death, and beyond, if necessary.
- Anticipatory grief services are provided to help patients, families, caregivers, and other individuals identified by the patient cope with the losses that occur during the illness and eventual death. Bereavement services are provided prior to and after death based on a plan of care created from a thorough bereavement assessment, including risk factors for complicated grief, social support, concurrent life stressors, relationship with the deceased, and other relevant factors.

Standard:

PFC 1: Hospice services are available twenty-four (24) hours a day, seven (7) days a week.

PFC 1.1 The hospice assures a timely response to patient and family/caregiver telephone calls 24 hours a day, 7 days a week.

PFC 1.2 Professional staff are available to make visits to address patient and family/caregiver needs 24 hours a day, 7 days a week.

PFC 1.3 Interdisciplinary team support is accessible and available 24 hours a day, 7 days a week.

PFC 1.4 Professional staff consultation and visits provide assessment, instruction, support, and interventions, as needed.

PFC 1.5 The hospice has reporting mechanisms and procedures to ensure that after regular business hours staff and volunteers are regularly informed and updated on the patient's current status.

Practice Examples:

- A system is in place to respond to contacts and meet patient and family needs in a timely way after regular business hours.

- Patients and families receive information at the time of patient admission – that is written and easily accessible – regarding how and when to access care after regular business hours. All team members regularly reinforce this information throughout the course of care.
- An established means of staff communication (e.g., written, electronic, voice mail) exists to assure the accurate and timely transmission of information on a daily basis.
- The hospice has an established method to relay documentation of actions taken after regular business hours (e.g., protected/encrypted emails and texts, faxes, documentation in the patient's electronic medical record (EMR)). On-call logs are used to document the response to all contacts and requests made after regular business hours.
- The interdisciplinary team creates recommendations, parameters for interventions, and updates for staff after regular business hours to ensure continuity of care. The updates include new or changed medications, changes in the patient's condition, a summary of current issues, individualized approaches, special concerns, and information on uncommon diagnoses.
- Policies and procedures have been established to ensure all levels of care are provided as needed and can be initiated 24 hours a day.

Standard:

PFC 2: Care is fully coordinated to ensure ongoing continuity for the patient, family, and caregiver.

PFC 2.1 The hospice has criteria and a written process for receiving referrals and verification of eligibility, which is used to make admission decisions for both adult and pediatric patients.

PFC 2.2 Procedures are established and utilized for initial and ongoing assessment of patients and families by all disciplines, including processes to evaluate special needs of children and Veterans, based on regulatory and hospice-defined time frames.

PFC 2.3 The hospice has criteria for determining appropriate levels of care, supports the decision regarding the level of care with documentation, and utilizes all levels of care based on patient and family needs.

PFC 2.4 The clinical record contains documentation of care coordination through documentation of interdisciplinary team conference meetings, telephone communication, after-hours contacts and actions, and visits by interdisciplinary team members.

PFC 2.5 The hospice team delineates a process to transition family members and caregivers from patient care to bereavement care.

PFC 2.6 Documentation supports the patient's continuing terminal prognosis and eligibility.

PFC 2.7 The hospice team coordinates care with non-hospice healthcare providers, resource providers, and vendors involved in the patient's care (e.g., community health programs, healthcare facilities, nursing homes, assisted living facilities, pharmacists, health insurance programs, physical and occupational therapists, speech language pathologists, specialist physicians, nurse practitioners, and physician assistants).

Practice Examples:

- The attending physician is informed of pertinent and significant changes related to the patient's condition and the plan of care.

- The nursing facility plan of care is integrated with the hospice plan of care and reflects efforts to promote collaboration, communication, and coordination to address the care needs of the nursing facility resident enrolled in hospice and family members or representatives of the resident.
- Interdisciplinary team meetings include contracted service providers, attending physicians (if any), volunteers, bereavement counselors, and family members/representatives when needed to address issues related to the coordination of care.
- The registered nurse (RN) who performs the initial nursing assessment will discuss and review the medical history, terminal and related diagnoses, medication review, and the plan of care with the hospice physician.
- Grief and bereavement needs are identified and addressed at the time of admission and throughout the episode of care. A plan for bereavement care following the death is created and addresses any survivor risk factors identified at the time of the bereavement assessment.
- Processes are established to determine which medications are related and unrelated to the terminal prognosis and related conditions and diagnoses. Responsibility for payment and provision of medications is coordinated with health plans and pharmacies to ensure timely decision making and pharmacy service delivery. Communication about responsibility for payment is documented.
- Processes are established in nursing facilities to coordinate hospice care and services provided to hospice-enrolled nursing facility residents between facility staff, the facility healthcare team, and the hospice interdisciplinary team.

Standard:

PFC 3: The hospice designates an interdisciplinary team that assesses need and plans, directs, coordinates, and evaluates effectiveness of care and services provided to the patient, family caregiver, and other family members.

PFC 3.1 The interdisciplinary team must include:

- Hospice physician;
- RN;
- Social worker;
- Pastoral or spiritual counselor; and
- Additional interdisciplinary team members may include:
 - Patient's attending physician (if any);
 - Other physicians involved in the patient's care;
 - Nurse practitioner;
 - Physician assistant;
 - Pharmacist;
 - Volunteer;
 - Bereavement counselor;
 - Hospice aide;
 - Physical therapist, occupational therapist, speech-language pathologist and/or dietary counselor; and
 - Other clinicians, counselors, or healthcare practitioners involved in the patient's care.

Practice Examples:

- Attending physicians (if any) are invited to attend interdisciplinary team meetings when their patient's care plan is scheduled for review and updating.
- Volunteers, bereavement counselors, physical therapists, occupational therapists, speech-language pathologists, and dietary counselors who provide patient support/care are invited to provide input, attend the interdisciplinary team meetings, and participate in discussions regarding their assigned patients.
- Staff members who serve in more than one capacity (e.g., spiritual care and bereavement) will maintain awareness of their respective professional roles to ensure healthy boundaries and clear communication in patient and family/caregiver relationships.
- Nursing facility staff members are invited to attend the interdisciplinary team meetings when care plans for residents who are hospice patients at their facilities are scheduled for review and updates.

Standard:

PFC 4: A written individualized plan of care is developed by the hospice nurse in collaboration with the other members of the interdisciplinary team. The care plan is based on information gathered from the initial and comprehensive assessment, reflects the needs of the patient and family, and addresses care and services to be provided.

PFC 4.1 Comprehensive assessments are completed to accurately reflect the patient's physical, psychosocial, emotional, and spiritual needs. The plan of care is based on comprehensive interdisciplinary assessments that include evaluation of physical, psychological, emotional, spiritual, medication, and equipment needs, including but not limited to:

- Patient and family goals for care;
- Principal and secondary diagnoses and any co-morbid conditions;
- Current medical findings, including clinical features and complications, that support the terminal prognosis;
- Patient's health status, including changes related to their terminal prognosis, symptoms, functional and cognitive status, coping ability, and spiritual/existential concerns;
- Family caregiver's functional and cognitive capacity, coping ability, anticipatory grieving, preparation for the death, and spiritual needs;
- Patient's and family's social support, cultural, and resource needs; and
- Patient and family special population needs such as Veteran status, children, disability; etc.

PFC 4.2 The plan of care includes strategies and planned interventions for addressing needs identified through assessment (e.g., the management of pain, symptoms, and psychosocial or spiritual concerns), as well as frequency of contact by the interdisciplinary team. The plan of care consists of but is not limited to:

- Patient and family preferences and desired outcomes;
- Patient and family caregiver needs;
- Interventions directed to achievement of desired outcomes and meeting the needs of the patient and family as identified by the interdisciplinary team;
- Scope, frequency, and type of services to be provided, including the interdisciplinary team interventions;
- Medications, medical equipment, and supplies necessary to meet the needs of the patient; and
- Agencies or organizations, healthcare providers, or services that may be involved in the care.

PFC 4.3 The patient and family are routinely engaged in developing the plan of care in a language and manner they can understand. The patient and family are informed about options for care and may participate in the patient's care planning.

PFC 4.4 The hospice documents patient and family participation, understanding, and level of agreement with the patient's plan of care.

Practice Examples:

- The initial assessment visit is completed by the hospice nurse. Other interdisciplinary team members, such as the social worker, may accompany the nurse.
- The plan of care is developed, based on assessments by the interdisciplinary team members, with the patient, family caregiver, hospice medical director, and attending physician (if any). The plan of care is reviewed and updated at least every 15 days or more frequently as indicated by changes in the patient's condition or family circumstances.
- With respect to the provision of hospice care to Veterans, the hospice uses a military history checklist to evaluate the impact of military experience and how that may impact care, as well as to determine if there are benefits to which the Veteran and surviving dependents may be entitled. Needs identified through use of the checklist are reflected in the plan of care.
- The plan of care is documented and communicated to all interdisciplinary team members involved in providing care and services to the patient and family.
- If the patient and/or family caregiver has limited English proficiency (LEP) or other unique communication needs, an approach to patient and family caregiver communication is documented in the plan of care (e.g., use of a language line translation service, TTY for individuals with hearing and/or speaking deficiencies, etc.). Utilization of family members as translators should not be a standard practice unless the patient or representative specifically requests it.

Standard:

PFC 5: The interdisciplinary team members implement the interventions identified in the plan of care.

PFC 5.1 The interdisciplinary team members provide services according to the scope and frequency specified in the plan of care.

PFC 5.2 The interdisciplinary team members' interventions are directed toward achieving the desired goals or outcomes in the plan of care.

PFC 5.3 Each interdisciplinary team member documents and communicates the interventions performed with the patient and family, their response to care and services provided, and the goals or outcomes achieved.

Practice Examples:

- The clinical record reflects the frequency of visits by the interdisciplinary team members is in accordance with the visit frequency stated in the plan of care.
- Documentation in the patient record by each interdisciplinary team member reflects and is consistent with the interventions related to the specific goals of care identified in the plan of care.
- During interdisciplinary meetings, team members discuss the interventions and plan for the patient's care.

Standard:

PFC 6: The interdisciplinary team reviews, revises, and documents the plan of care to reflect the specific and changing needs of the patient and family.

PFC 6.1 The plan of care is reviewed, revised, and documented in the patient's clinical record by the interdisciplinary team at least every 15 calendar days.

PFC 6.2 Reassessment is performed during any contact by interdisciplinary team members with the patient and/or family.

PFC 6.3 The interdisciplinary team revises the plan of care on an ongoing basis in response to changes in the status and care needs of the patient and the family.

PFC 6.4 Interdisciplinary team meeting documentation reflects the ongoing assessment of the patient's and family's needs, as well as their participation in and agreement with the development and revision of the plan of care.

Practice Examples:

- The patient's and family's needs are reassessed during each visit by interdisciplinary team members and documented in the patient record.
- Significant information obtained during patient and family reassessment that is relevant to the plan of care is immediately communicated with other interdisciplinary team members and documented in the clinical record. The plan of care is collaboratively revised accordingly.
- For facility residents who are enrolled in hospice, documentation in the patient record demonstrates collaboration by hospice team members and facility staff, and the plan of care is revised in response to the patient's and family's reassessment.
- The nursing facility plan of care is integrated with the hospice plan of care and reflects collaborative efforts to address the care needs of the hospice-enrolled nursing facility resident, the family representative, and facility staff.

Standard:

PFC 7: A RN coordinates the delivery of care provided by the hospice interdisciplinary team of professionals and volunteers to ensure that the patient's and family's needs are continuously assessed, planned for, and addressed.

PFC 7.1 The hospice RN coordinates care, taking into consideration the patient's and family's needs and strengths and the health professionals involved in the care.

PFC 7.2 The hospice RN's responsibilities include:

- Coordinating the interdisciplinary team to ensure adequate assessment, planning, and implementation of each patient's and family's plan of care; and
- Ensuring effective interdisciplinary team practice, coordination, and communication among team members.

Practice Examples:

- The hospice has a written job description describing the qualifications and responsibilities for the RN as the case manager.
- Care coordination by the nurse case manager among interdisciplinary team members and across care settings is observable through a review of interdisciplinary team conference notes, telephone communication, and clinical visit notes in the patient's clinical record.

Standard:

PFC 8: The interdisciplinary team identifies a patient's values, spiritual beliefs, and/or philosophies and honors these perspectives in all care coordination and planning.

PFC 8.1 A spiritual assessment is completed as part of the comprehensive assessment, and spiritual support is provided according to patient and family preferences and needs.

PFC 8.2 The interdisciplinary team recognizes feelings and concerns such as loneliness, guilt, fear, and anger, which may be shared by the patient and family, and addresses these according to patient and family preferences and needs.

PFC 8.3 The interdisciplinary team assesses patient and family culture, history, and other pertinent dynamics and utilizes the assessment as the basis for understanding and supporting patient and family wishes when developing appropriate interventions.

Practice Examples:

- The care planning process delineates procedures and protocols to include the patient's spiritual support system, as defined by the patient, in the care planning process.
- A spiritual assessment that addresses spiritual issues and concerns is completed as a part of the comprehensive assessment within five (5) days of electing hospice care.
- Documentation in the patient record indicates that the patient's spiritual beliefs and traditions are communicated to and supported by the interdisciplinary team.
- All staff receive training to ensure an understanding of the ethical boundaries prohibiting the imposition of one's own beliefs on the patient and/or family.

Standard:

PFC: 9 The interdisciplinary team promotes opportunities for integration, reconciliation, and closure according to the patient's preferences and needs.

PFC 9.1 The interdisciplinary team helps the patient identify critical aspects to achieving integration, reconciliation, and end-of-life closure including self, family, friends, and community.

PFC 9.2 The patient's strengths and unique qualities are supported by interdisciplinary team members.

PFC 9.3 Additional support is offered and provided according to the patient's preferences as the patient approaches death.

PFC 9.4 Cultural perspectives and beliefs on death are recognized, honored, and supported in ways that are meaningful to the patient and family.

Practice Examples:

- The hospice has written materials that explain what to expect during the dying process for the patient and family (e.g., signs and symptoms of approaching death) in a manner and language that both parties understand.
- The hospice develops specially trained volunteer teams to provide patient and family support, such as a vigil program, as death approaches.
- At the patient's request, the hospice chaplain or designated spiritual care coordinator facilitates patient contact with a faith community when the patient has been inactive for some time due to the progression of the patient's illness.
- At the patient's request, hospice staff may seek to facilitate visits for special needs, such as immigration problems or incarceration issues.
- Following the patient's death, the hospice interdisciplinary team provides care of the body, honors cultural rituals when possible, and assists the family with funeral arrangements as needed.

Standard:

PFC 10: The patient's ability for self-care is regularly assessed, and interventions are implemented in accordance with patient and family wishes when the patient is no longer able to adequately provide self-care.

PFC 10.1 Medical equipment and supplies are provided to assist in the care of the patient as indicated.

PFC 10.2 Policies and procedures are developed to plan for patient care when there is no primary caregiver in the patient's residence.

PFC 10.3 Communication strengths and barriers (e.g., cognitive deficits, LEP, etc.) are routinely assessed, and appropriate actions are taken to ensure the patient's understanding of care.

PFC 10.4 When indicated, a coordinated transition to another setting is facilitated by the interdisciplinary team to meet the patient's care needs.

Practice Examples:

- The hospice ensures that non-English speaking patients and their families readily have access to information in an understandable form by providing literature written in languages for non-English speaking communities common in the hospice's service area and providing access to translators twenty-four (24) hours a day, seven (7) days a week.
- Assistive technology (e.g., assistive listening devices (ALDs)) are available to the deaf and hearing impaired through local community TYY service providers.
- The hospice has appropriate procedures in place to support education and communication with those who have a limited ability to read and/or write and, when creating written materials, is mindful that much of the general population reads on a fifth-grade level.

- Hospice staff proactively work with patients and families to plan for a higher level or increased intensity of care as needed (e.g., when the patient's condition changes).
- The hospice helps the patient who lives alone to explore possible options for care when the patient can no longer care for themselves such as a nursing facility, a hospice residence, a family member's home, or paid or unpaid assistants in the home.

Standard:

PFC 11: The family's ability to emotionally and/or spiritually adjust to changing conditions is assessed as part of the ongoing, comprehensive psychosocial and spiritual assessment.

PFC 11.1 The care planning process includes interventions that address the needs and goals of the family related to end of life care, loss, and grief.

PFC 11.2 Family members' spiritual beliefs, traditions, and rituals are respected during the care planning process.

PFC 11.3 Family members' feelings of loss, despair, loneliness, unresolved guilt, fear, and anger are recognized and addressed by the interdisciplinary team.

PFC 11.4 Appropriate and timely communication and education are provided to the patient and family from admission to discharge or death, and through bereavement.

Practice Examples:

- Psychosocial assessment tools include assessment of family history and coping skills.
- Family discord is identified and addressed in the plan of care as it relates to or impacts patient wellbeing and care needs.
- Bereavement staff routinely attend interdisciplinary team meetings and participate in the care planning process.
- The hospice interdisciplinary team counsels patients and families who cannot take leave from work after the patient is diagnosed with a terminal illness.
- A hospice counselor meets with the caregiver to assist with unresolved grief issues from the past and anticipatory grief.
- The hospice interdisciplinary team respects and normalizes feelings of anger experienced by a young patient's parents as they live with the reality of their child's illness.
- The hospice interdisciplinary team counsels a patient and family in dealing with issues of post-traumatic stress disorder or other disorders due to the patient's military history and combat duty experience.
- The hospice bereavement counselor assists a patient's spouse with coping with multiple recent family losses, occurring over a short time span.
- The hospice interdisciplinary team educates the family on what to expect at the time of death and bereavement by using appropriate teaching tools.
- The hospice interdisciplinary team assists the patient's same-sex partner in navigating legal and financial challenges related to decision-making for the patient.
- The hospice respects the patient and family's requests for no visits on religious observations dates.

Standard:

PFC 12: The hospice interdisciplinary team promotes opportunities for reconciliation and end-of-life conversations according to the patient's and family's preferences.

PFC 12.1 The interdisciplinary team helps the patient and family members identify important subject areas for reconciliation and end-of-life conversations.

PFC 12.2 The interdisciplinary team facilitates communication between the patient and family members by encouraging expression of emotions related to grief and loss (e.g., love, concern, regret, gratitude, and forgiveness), as appropriate, based on the needs and desires of the patient and family.

PFC 12.3 Family members are educated about the physical, psychological, emotional, and spiritual aspects of the dying process.

PFC 12.4 The interdisciplinary team nurtures and supports a sense of meaning for family members related to their relationships with each other and the family's identity within the community.

Practice Examples:

- Family members are encouraged to meet individually with the patient and express their feelings, facilitated by the hospice social worker and spiritual counselor or chaplain, if desired.
- Family members are educated about the patient's possible withdrawal from others as death approaches and are supported as they continue to care for the patient.
- The hospice uses a reminiscence tool to help the patient and family remember and appreciate their lives together (e.g., journals, CDs, photos), with possible utilization of expressive therapy.
- The interdisciplinary team facilitates family meetings, as needed or desired, to help resolve issues and make decisions related to the patient's plan of care.

Standard:

PFC 13: The interdisciplinary team evaluates and supports the family's physical, cognitive, and social capacity to communicate, learn, and carry out caregiving responsibilities.

PFC 13.1 Patient care and physical safety are regularly evaluated. Safety interventions are incorporated in the care planning process as needed.

PFC 13.2 The caregiver's willingness and ability to participate in the patient's care is regularly evaluated, and interventions for change or improvement are incorporated into the care planning process, as needed.

PFC 13.3 Cultural language barriers, disabilities, caregiver burden, and other factors that impact communication are recognized in the caregiving process. Interventions are developed to support learning and effective caregiving.

PFC 13.4 The hospice takes a proactive approach to medication safety with particular attention to opioid safety, to ensure that all medications are used safely. This includes the following:

- Conduct Opioid Risk Assessment, including use of a locked safety box if necessary;
- Identify who will control patient's medication administration; and
- Conduct Opioid Safety Education.

Practice Examples:

- At the patient's request, the hospice nurse and/or other interdisciplinary team members regularly communicate with family members, including those residing outside the immediate community, to update them on the patient's condition.
- Volunteers are assigned to provide support services to the patient when a family member needs coverage for special circumstances.
- The hospice offers respite care to family members to support the patient to stay in their own home as long as possible by easing caregiver burden.
- Interpreter services or other language and communication strategies are available and utilized as appropriate.
- The hospice plan of care reflects specific arrangements for the reconciliation of opioids on every RN visit, safe medication storage and administration, and review of the safety plan with the patient and family if risk of diversion is identified.
- The hospice team engages in contractual agreements with the patient and family regarding unresolved safety issues to ensure staff and patient safety (e.g., smoking with oxygen, multiple falls, lack of patient supervision, weapons, abusive/violent behavior, etc.).

Standard:

PFC 14: The interdisciplinary team assesses the patient's and family's environmental and financial resources as they relate to the provision of patient care.

PFC 14.1 Housing, welfare, caregiver burden, and safety issues, such as problems with shelter or inadequate financial resources, are identified. Interventions are initiated according to patient and family preferences.

PFC 14.2 Personal business and family welfare issues, such as funeral and memorial service arrangements or financial, legal, and other services, are identified and interventions are initiated according to patient and family preferences.

Practice Examples:

- The interdisciplinary team educates the family on the importance of self-care, provides or suggests opportunities for additional support, and arranges for respite care to reduce caregiver burden.
- The interdisciplinary team assists family members with additional care options, including placement for the patient as needed and appropriate, taking into consideration patient and family preferences and financial capability.
- The interdisciplinary team assists the patient and family in completing advance directives and other end-of-life planning tools (e.g., Physician Orders for Life Sustaining Treatment (POLST), Five Wishes, etc.) and educates the patient and family on the meanings of these documents on an on-going basis.
- The interdisciplinary team assists families with funeral or memorial service arrangements, and the hospice spiritual care coordinator or chaplain helps plan and conduct services as requested.
- For patients without third-party payer coverage who are unable to pay for medically necessary hospice care, the interdisciplinary team offers the option to complete a financial needs assessment for agency-sponsored financial assistance and facilitates the completion of the assessment, if necessary.

Standard:

PFC 15: An assessment of patient and family feelings, strengths, goals, and needs related to loss, grief, and bereavement is performed. Interventions are developed based on the assessment and are incorporated into the interdisciplinary plan of care.

PFC 15.1 The interdisciplinary team works in partnership with the patient and family to identify issues that may complicate life closure.

PFC 15.2 The interdisciplinary team encourages, facilitates, and validates the patient's and family's expressions of grief related to losses identified by the patient and family.

PFC 15.3 The interdisciplinary team supports patients and families in their grief process through direct services and by referrals to appropriate community resources for additional assistance if needed.

PFC 15.4 Survivor risk and bereavement assessment tools are utilized by the hospice from admission throughout the course of care and through thirteen (13) months after the death.

PFC 15.5 The interdisciplinary team identifies, documents, and addresses the patient's and family's needs and goals related to anticipatory grief (before death) and bereavement (following death).

PFC 15.6 The interdisciplinary team documents the evaluation of bereavement needs, the hospice's response to assessed needs, and the bereaved person's response to services provided.

Practice Examples:

- A bereavement risk assessment is completed at the start of care to identify risk factors for complicated grief.
- Bereavement staff make visits to the patient and family prior to the patient's death in accordance with the plan of care.
- The hospice interdisciplinary team utilizes complementary therapies to assist in facilitation of a patient's expressions of feelings or to provide comfort.
- Children who are impacted by the patient's death are identified, and a plan is developed to respond to their needs.
- The patient and family receive education regarding grief and loss and are offered bereavement counseling.

Standard:

PFC 16: Prepare and support the family prior to and at the time of the patient's death.

PFC 16.1 The interdisciplinary team will, through written materials and verbal instructions, support families in understanding the signs and symptoms related to the final stages of illness and the dying process.

PFC 16.2 The interdisciplinary team will ensure that families have opportunities to discuss their thoughts and feelings related to the final stages of illness, and to receive support in ways that are meaningful to them.

PFC 16.3 Interdisciplinary team members are available to attend a patient death twenty-four (24) hours a day, seven (7) days a week.

PFC 16.4 Hospice staff attending a patient's death respect the cultural, religious, and spiritual traditions and beliefs of the patient and family.

PFC 16.5 Each patient death is confirmed, documented, and communicated according to applicable state laws and regulations and in accordance with the hospice' policy.

PFC 16.6 The patient's body is handled with respect and dignity and in accordance with the patient's and family's requests and wishes.

Practice Examples:

- Family members and caregivers are informed of standard notification procedures prior to the patient's death.
- On-call services support the capability of staff attendance at all deaths in all settings.
- The hospice staff attend and verify a patient's death pursuant to state regulations and/or state scope of practice requirements. The hospice has specific procedures related to documentation of a patient's death, including care of the body, disposal of medications per federal and state regulations, and other required notifications.
- Family members are afforded time with the patient's body as desired and per cultural customs.
- On-call spiritual care staff are provided appropriate contact information for the family and other information to support the plan of care regarding cultural, religious, or spiritual traditions and beliefs of the patient and family at the time of death.

Standard:

PFC 17: The hospice has a well-defined bereavement program that begins at start of care and provides services for a minimum of thirteen (13) months following the death of the patient.

PFC 17.1 The hospice has bereavement policies and procedures that delineate the scope of bereavement care provided and incorporate confidentiality procedures and mechanisms to assure that family preferences regarding bereavement contact are honored.

PFC 17.2 The hospice bereavement policies and procedures specify the services to be consistently provided within specific time frames during the course of bereavement care.

PFC 17.3 Guidelines for the hospice bereavement program clearly describe the nature of counseling services to be provided within specific time frames, as well as the nature and constraints of such services.

PFC 17.4 The hospice has a systematic and ongoing method of evaluating the outcomes and effectiveness of the bereavement services provided.

PFC 17.5 The hospice defines eligibility criteria for bereavement services that considers the needs of bereaved community members.

Practice Examples:

- Bereavement services may include, but are not limited to:
 - Individual and family counseling;
 - Grief support groups, general and specialized, for all age groups;
 - Family support visits;
 - Telephone support;
 - Written materials about grief and coping that are appropriate for the age, language, average reading level, and special needs of the bereaved population;
 - Scheduled mailings (e.g., personal, educational, and informational);
 - Memorial services and funerals;
 - Camps and retreats;
 - Spiritual and pastoral counseling;
 - Internal in-service programs;
 - External educational offerings; and
 - Referral to community resources
- Bereavement counseling services are based on the understanding grief is a normal part of life and can be navigated successfully with adequate support.
- Bereavement counseling for manifestations of non-complicated grief includes empathy and compassion, active listening, normalizing the grief experience, education, recognition of the bereaved person's natural resilience, encouragement, problem-solving, and the reinforcement of adaptive coping strategies.
- Bereavement outcomes are identified, and data are collected and analyzed on an ongoing basis to measure the effectiveness of services provided and develop strategies for improvement.
- A means of communicating with out-of-area family members is developed to provide bereavement information and to identify supportive resources in their area, if desired.
- Childhood loss and grief counseling and other programs are designed and provided consistent with bereaved children's developmental phases and special needs.

Standard:

PFC 18: A plan of care – inclusive of bereavement needs, interventions, goals, and outcomes – is developed and documented for families served by the bereavement program.

PFC 18.1 Goals and outcomes related to bereavement care are part of the ongoing care planning process and are determined by family members in collaboration with the interdisciplinary team/bereavement staff.

PFC 18.2 The plan of care for bereavement services should reflect family needs and delineate the specific services provided, including the means for service provision and frequency of contact.

PFC 18.3 Bereavement needs, services, and interventions are documented in the patient's clinical record during care of the patient, and in a separate record for the bereaved individuals following the patient's death.

PFC 18.4 Routine bereavement services are available and offered to the family regardless of risk factors.

PFC 18.5 Family members whose needs are assessed to be beyond the scope of the hospice bereavement program are referred to appropriate community agencies or practitioners.

Practice Examples:

- The plan of care identifies the interventions to meet the family's needs and preferences, including the frequency of contact.
- Bereavement goals and outcomes are regularly reviewed with the individuals who are receiving bereavement services.
- A plan is developed to address the needs of those survivors identified as at-risk for complicated grief reactions.
- A list of community resources or practitioners is maintained for referral of family members whose needs are assessed to be beyond the scope of the hospice bereavement program counseling services.
- A bereaved child's record includes consent for care from the parent/guardian and ongoing communication of progress, needs, and therapies with the parent/guardian.

Standard:

PFC 19: The hospice utilizes qualified staff and volunteers to provide bereavement services.

PFC 19.1 Bereavement services are managed and coordinated by qualified, professional hospice staff with education and training appropriate to the position's responsibilities.

PFC 19.2 Bereavement services are provided by appropriate hospice staff and volunteers who receive routine clinical supervision by qualified bereavement professionals.

Practice Examples:

- The hospice utilizes staff with degrees in clinical social work, mental health counseling, or other related fields (e.g., spiritual counseling) to provide bereavement services.
- Volunteers receive additional bereavement-specific training including but not limited to: supportive listening; communication skills; general concepts of grief and loss including risk factors for complications in bereavement; professional boundaries; spiritual and/or religious boundaries; stress management; self-care; and collaboration and communication with the team/bereavement staff.
- The hospice ensures clinical staff is comprehensively trained in loss, grief, and bereavement and are regularly offered continuing education opportunities in grief and loss, such as identifying high risk survivors and those at-risk for complicated grief reactions.
- The hospice has a plan for providing regular and ongoing supervision of bereavement staff and volunteers.
- The hospice documents the bereavement services provided.
- The hospice defines bereavement staff roles and responsibilities for providing bereavement support to clinical staff and volunteers.



Ethical Behavior and
Consumer Rights (EBR)

Ethical Behavior and Consumer Rights (EBR)

Principles

A hospice upholds high standards of ethical conduct and advocates for the rights of patients and their family caregivers. The hospice respects and honors the rights of each patient and family it serves. The hospice assumes responsibility for ethical decision-making and behavior related to the provision of hospice care.

Advance care planning information and state-specific advance directives are available through NHPCO's CaringInfo, which provides free resources to educate and empower patients and caregivers to make decisions about serious illness and end-of-life care and services. For more information about CaringInfo, visit www.caringinfo.org.

Standard:

EBR 1: The hospice maintains the patient's right to be involved in all decisions regarding the patient's care, treatment, and services.

EBR 1.1 Patients are provided education and opportunities to review the hospice's approach to care, treatment, and focus on palliative care services at the time of admission and throughout the course of care. Families/caregivers are involved per patient wishes or surrogate state-based decision-making laws are followed, as applicable.

EBR 1.2 Informed consent for hospice care is obtained from the patient or legally authorized representative and is documented in the clinical record.

EBR 1.3 The hospice obtains information related to the patient's advance care planning status, conditions, and specifications; educates the patient and family/caregiver on the importance and benefits of advance care planning; and identifies additional resources for completing an advance directive, if requested. The hospice documents the information in the clinical record for patients of all ages.

EBR 1.4 Decisions regarding care or services to be provided are based on the patient's (or legally authorized representative) preferences and goals for care, are communicated to the patient and family/caregiver, and are documented in the clinical record.

EBR 1.5 The organization respects the patient's right to choose and discontinue hospice services.

EBR 1.6 The hospice provides verbal explanation and written information about the organization's policies on advance directives, including a description of relevant state law(s).

EBR 1.7 Prior to the provision of services or any change in services, the hospice informs patients and families of policies regarding discontinuing services and any potential costs to them. The hospice documents the patient's or the financially responsible party's understanding of that information.

EBR 1.8 The hospice has a process in place to ensure that the patient's designated representative has the authority to make decisions on behalf of the patient in accordance with state laws and regulations.

EBR 1.9 The hospice provides interpretation and translational services for patients with limited English proficiency (LEP). Written materials are developed in the patient's preferred language as needed or desired.

EBR 1.10 The hospice has a process in place to ensure that the patient's designated representative is identified and confirmed and has the authority to make decisions on behalf of the patient in accordance with state laws and regulations.

EBR 1.11 The hospice has a written policy that includes a clear and precise statement of limitations if a staff member or the hospice program cannot implement the legally authorized surrogate's treatment request, whether in the form of a real-time written or verbal request, or an advance directive based on conscience.

Practice Examples:

- On admission, the hospice educates the patient and family/caregiver about hospice care and specific hospice services. In addition, the hospice explains insurance coverage and patient rights under that coverage.
- Families/caregivers are made aware of core hospice services available to them, including psychosocial, spiritual, volunteer, and bereavement services.
- On admission and prior to provision of care, the hospice educates each patient about their right to formulate an advance directive. The patient's decision is documented in the clinical record.
- The patient's (or their legally-authorized representative's) desires related to end-of-life care decisions are documented in the psychosocial assessment, which is a part of the overall comprehensive assessment.
- The hospice does not require specific provisions in advance directives (e.g., a Do Not Resuscitate (DNR) order) as a condition of admission.
- The hospice consults United States Census information or the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) list of the top 15 languages spoken by individuals with LEP in each state, the District of Columbia, and each U.S. Territory (see HHS website for more information) to determine prevalence of various languages in the service area and makes written materials available in languages commonly found in the hospice's service area.

Standard:

EBR 2: Hospice patients and their families have the right to confidentiality.

EBR 2.1 The hospice has written policies and procedures regarding privacy and the protection of information from inappropriate and/or unlawful disclosure, which conform to federal regulations and recognize that patients may be entitled to confidentiality from disclosure to family or caregivers.

EBR 2.2 Individual patient confidentiality is protected by obtaining signed approval from the patient or designated representative for recordings, films, or other images and in data collection, aggregation, and submission to an outside entity.

EBR 2.3 All staff members, including volunteers, are educated about patients' rights to privacy and the hospice's obligation to confidentiality through policies and procedures.

EBR 2.4 During orientation and prior to any exposure to patient or family caregiver information, all staff members, including volunteers, agree in writing to maintain patient confidentiality.

EBR 2.5 The hospice maintains compliance with all components of the Health Insurance Portability and Accountability Act (HIPAA) and discloses health information only as authorized and in accordance with federal and state laws and regulations.

Practice Examples:

- Any patient information carried in staff vehicles is handled in a manner such that patient names, diagnoses, or clinical reports are not discernable.
- The hospice staff asks for the patient's permission before touching the patient.
- The hospice staff know how to respond appropriately when asked by concerned individuals about patients.
- The hospice staff ensure that patients' protected health information is not left exposed in open work areas and uses security tools, such as computer privacy screens.
- The hospice has defined procedures for the disposal of documents that contain protected health information, such as use of a paper shredder or other shredding service.
- The hospice's electronic records and communications accessed through portable devices (e.g., laptops, cell phones, etc.) meet HIPAA and Health Information Technology for Economic and Clinical Health (HITECH) requirements and guidelines regarding passwords, locking, and secure networks.

Standard:

EBR 3: Patients and their families have the right to have their complaints heard and addressed.

EBR 3.1 The hospice has a formal process in place, that is initiated whenever a complaint is received, to work toward resolution of the complaint. The hospice documents this process and resolution, including the follow-up performed with the patient/family/caregiver.

EBR 3.2 At the time of admission, the hospice informs patients and their families/caregivers of both the hospice's internal complaint resolution process and external processes. The hospice also provides patients and their families/caregivers a list of independent third-party entities where complaints can be filed, along with information on how to contact them.

EBR 3.3 Complaints are tracked via a complaint log and regularly reviewed to identify any patterns or trends.

EBR 3.4 Staff members are educated about the complaint resolution process and accept responsibility for helping to identify and address complaints.

EBR 3.5 The patient's and family/caregiver's views are respected, and their expression of a grievance does not result in discrimination or reprisal.

Practice Examples:

- The hospice interdisciplinary team reviews any patient or family complaints about care provided and takes timely, remedial action as appropriate.

- The hospice designates a staff member who is responsible for complaint follow-up, resolution, and documentation.
- Information on how to voice a complaint is provided in writing to the patient and family/caregiver, listing specific contact names and numbers of hospice leadership staff and the contact information for the state survey agency.
- The staff is educated in complaint resolution techniques that are constructive and do not place blame on others.
- Information gathered through the complaint process is regularly monitored as part of the hospice's Quality Assurance and Performance Improvement (QAPI) program. Trends are identified as opportunities for improvement in care and outcomes.

Standard:

EBR 4: The hospice acknowledges and respects each patient's and family/caregiver's rights and responsibilities.

These include the patient's and family/caregiver's right to:

- Be treated with respect;
- Receive quality end-of-life care;
- Receive effective pain and symptom management;
- Be involved in care plan development;
- Refuse care or treatment;
- Choose their attending physician (e.g., a patient has the right to request their personal/community physician remain their attending physician if the personal/community physician is willing);
- Confidentiality of information;
- Be free from abuse, mistreatment, and neglect;
- Receive information about hospice insurance coverage and patient cost-sharing;
- Receive information on advance directives
- Receive information about hospice services and limitations thereof;
- Be free from discrimination or reprisal for exercising their rights; and
- Access and request a copy their clinical record.

EBR 4.1 Upon admission, the hospice informs each patient and family/caregiver of the patient's rights, both verbally and through a written statement.

EBR 4.2 The hospice has written policies and procedures that address:

- The purpose and scope of hospice services;
- Informed consent by the patient/family for the provision of hospice services;
- Authorized designated or legal/authorized representative consent according to state laws; and
- Staff education related to patient and family/caregiver rights and responsibilities.

EBR 4.3 Signed documentation acknowledging the patient and family/caregiver received an explanation of the patient's rights is included in the patient's medical record.

Practice Examples:

- The hospice has a clinical record review process to verify each patient and family/caregiver received an explanation of the patient's rights and responsibilities.

- A statement of hospice patient rights is included in each admission packet or booklet.
- The hospice explains the patient's rights and responsibilities in a manner the patient and family/caregiver understand during the admission visit.
- Family/caregivers are informed at the time of admission of the consequences for certain decisions that may impact patient care (e.g., calling 911, obtaining unauthorized services).
- Hospice staff address the patient by their preferred name.
- Hospice staff report all suspected or actual incidences of mistreatment, neglect, abuse(s), or injuries of unknown source and misappropriation of patient property.
- Hospice leadership investigate all suspected or actual incidences of mistreatment, neglect, abuse(s), or injuries of unknown source and misappropriation of patient property through interviews, observations, record reviews, and other appropriate means.
- Hospice staff review written advance directives with the patient or authorized legal representative to determine, understand, and validate the patient's current wishes for care.
- Hospice staff work with the patient's designated family members to review the patient's advance care directives and wishes for care.

Standard:

EBR 5: Each hospice interdisciplinary team member recognizes and demonstrates a fiduciary relationship, maintains professional boundaries, and understands that it is their personal responsibility to maintain appropriate relationships with the patient, family, and caregivers.

EBR 5.1 The hospice provides orientation and training for staff, including volunteers, regarding the patient's rights and responsibilities.

EBR 5.2 The hospice provides orientation and training for staff, including volunteers, regarding the importance, principles, and maintenance of professional boundaries.

EBR 5.3 The hospice provides orientation and training for staff, including volunteers, regarding the fiduciary responsibility of the hospice to protect the interests of patients and families, including prohibited conflicts of interest.

Practice Examples:

- Hospice staff, board members, and volunteer personnel records include a signed conflict of interest statement on an annual basis that addresses both paid and unpaid staff.
- Hospice policy states staff may not communicate with the media without the administration's knowledge or permission.
- The hospice has a policy that addresses acceptance of money or gifts from patients or family members.
- The hospice develops a policy that restricts hospice staff, including volunteers, from giving patients or family members/caregivers their personal contact information (e.g., home phone numbers, cell phone numbers, email addresses).

Standard:

EBR 6: The hospice has a mechanism in place to assist the hospice interdisciplinary team to resolve conflicts or uncertainties about values that arise during the provision of care to patients and families/caregivers.

EBR 6.1 The hospice establishes procedures (e.g., an ethics consultation service) to identify, review, and discuss ethical dilemmas that cannot be resolved by professional practice guidelines or hospice policies and procedures.

EBR 6.2 Hospice staff are educated about ethics in hospice care and the hospice program's procedures for addressing ethical issues.

EBR 6.3 All referrals to ethics consultation service are tracked via an ethics consult log and regularly reviewed to identify any patterns or trends.

EBR 6.4 Hospice has a comprehensive ethics policy that addresses key topics such as composition and responsibilities of an ethics committee (e.g., membership, training and records, and ethics consultation service).

Practice Examples:

- The hospice has access to an ethics committee or ethical expertise. This may include a hospice's consultation with a trained clinical ethicist to review and discuss ethical considerations related to patient care or end-of-life care issues (e.g., requests for physician-assisted death, pediatric care, withdrawal of life-sustaining care or life support, and caregiver safety).
- The hospice policy on ethics consultation notes that a physician order is not needed for an ethics consult.
- The hospice has a policy that addresses the withdrawal of life-sustaining interventions (e.g., enteral and parenteral nutrition, implanted cardiac defibrillator, ventilator).
- The hospice includes an ethics component in orientation for new staff and volunteers.
- The hospice has a Code of Ethics to guide ethical decision-making.
- New hospice clinical staff complete a competency-based educational module on ethics as part of orientation.

Standard:

EBR 7: The hospice acknowledges and respects the rights and responsibilities of volunteers, supporting and empowering them in their role.

EBR 7.1 The hospice has written guidelines that encourage surviving family members/caregivers to wait a minimum of one year following the patient's death before serving as a hospice volunteer.

EBR 7.2 The hospice has a process to screen and evaluate individuals who wish to serve in a volunteer capacity to ensure compliance with established qualifications and regulations for hospice volunteers.

EBR 7.3 The hospice has written guidelines for employees related to working with volunteers.

EBR 7.4 The hospice fully orients volunteers to the role and expectations of the hospice volunteer, including the importance of maintaining boundaries with patients and caregivers.

EBR 7.5 The hospice provides clear role delineation guidelines for its volunteers and ensures that each individual volunteer assignment is within the scope of the accepted role and duties of hospice volunteers.

EBR 7.6 The hospice provides ongoing supervision and access to support for volunteers.

Practice Examples:

- Volunteer recruitment brochures clearly identify qualifications pertaining to volunteering after a death in the family.
- New volunteer orientation includes training related to maintaining boundaries with patients and families/caregivers.
- The volunteer coordinator maintains close contact with, and provides individualized support for, all volunteers who provide direct patient care. The volunteer coordinator pays particular attention to identifying potential conflicts of interest, ethics violations, and burnout.

Standard:

EBR 8: The hospice ensures all alleged violations of patient rights are reported immediately by the hospice staff, including contracted and arranged service providers, to the hospice administrator or a staff designee for appropriate action.

EBR 8.1 The hospice has written policies and procedures that guide the reporting of alleged violations and caregiver misconduct and include required time frames for reporting in accordance with Federal and/or state law.

EBR 8.2 The hospice administrator or staff designee investigates alleged violations and, if verified, the hospice reports the violation to state and federal authorities in the timeframe required by law.

EBR 8.3 The hospice administrator or staff designee assesses the current safety and comfort of the patient at the time of the reported allegation.

Practice Example:

- If hospice staff observe evidence of potential or actual mistreatment of a patient, they must immediately report what they saw to the hospice administrator (and facility administrator if patient resides in a nursing facility), as indicated, for investigation according to the hospice policy.

Standard:

EBR 9: The hospice keeps the interests of the patient and family/caregiver, and provision of high-quality care, a priority in all business practices.

EBR 9.1 The hospice has processes in place to ensure program integrity, accountability, and transparency in its business practices.

EBR 9.2 Business and marketing practices are carried out within the parameters of all relevant ethical, legal, and regulatory frameworks (see NHPCO Resource: Hospice and Palliative Care: Ethical Marketing Practices).

EBR 9.3 Admission and discharge practices maximize access to care for all patients who meet eligibility requirements for receiving hospice care.

EBR 9.4 The hospice truthfully and accurately represents its capacity and services in all marketing, outreach, and education activities and media.

EBR 9.5 Involvement of patients and families in marketing and outreach are conducted so that their confidentiality, privacy, and physical and emotional wellbeing are maintained and respected.

Practice Examples:

- The hospice discloses to every patient and family/caregiver any ownership interests or business relationships between the referral source and the hospice.
- A valid signed patient/family agreement is obtained by the hospice, using a clearly stated consent form, prior to using patient/family/caregiver stories, testimonials, and images in marketing materials.
- When doing informational presentations, hospice staff describe the full range of services available and the limitations of those services (e.g., the hospice does not provide hospice aides for round-the-clock custodial care, provision of like medications from organization's formulary, and not providing CPR if patient is in a full code and hospice staff is not CPR certified).
- The hospice provides the option to all patients and families/caregivers of opting out of receiving information related to the hospice's marketing and outreach activities.



Clinical Excellence and Safety (CES)

Clinical Excellence and Safety (CES)

Principles

The hospice ensures clinical excellence and safety promotion through standards of practice. The desired outcomes of hospice interventions are: (1) patients feel safe and comfortable throughout the dying process; and (2) patients and families feel supported and have adequate information appropriate to their needs throughout the trajectory of the illness, the dying experience, and for the first year or longer after the death. Hospice outcomes are individualized through a collaborative and reiterative process between the hospice interdisciplinary team and the patient/family/caregiver system. This process includes continuous assessment and identification of the goals, needs, strengths, and wishes of the patient and family/caregiver. The hospice provides for the safety of all staff while promoting the development and maintenance of a safe environment for patients and families/caregivers served.

Standard:

CES 1: The comprehensive assessment performed by the hospice interdisciplinary team and the patient's goals for care serve as the basis for the development of the patient's plan of care.

CES 1.1 Initial information documenting the patient's terminal prognosis and principal diagnosis, as well as contributory and secondary diagnoses, is obtained and reviewed prior to admission to hospice services.

CES 1.2 The hospice nurse makes an initial assessment within 48 hours of the effective date of the patient's hospice election statement and addresses the immediate needs of the patient.

CES 1.3 The hospice interdisciplinary team, in consultation with the patient's chosen attending physician, completes the comprehensive assessment within five calendar days of the effective date of the hospice election statement.

CES 1.4 The comprehensive assessment identifies the physical, psychosocial, emotional, spiritual, bereavement, and educational needs of the patient and family/caregiver that must be addressed to promote the patient's definition of wellbeing, comfort, and dignity throughout the dying process.

CES 1.5 The comprehensive assessment includes:

- The patient's immediate care needs on admission;
- Physical, psychosocial, emotional, spiritual, bereavement, and educational needs related to the terminal prognosis and principal diagnosis, plus related conditions;
- Comprehensive safety assessment that includes fall risk, oxygen safety, medication safety, suicide risk, weapon safety, physical environment, and caregiving support;
- Patient and family/caregiver hopes and wishes, which incorporate goals and preferences for caregiving, learning styles, educational needs, communication preferences, and other areas of concern;
- Patient and family/caregiver preferences regarding end of life, including rituals, atmosphere, surroundings, and visitors;
- Patient and family/caregiver preferences for life sustaining treatments and hospitalization;

- Cognitive status evaluation;
- Condition(s)/diagnoses causing and contributing to the terminal prognosis;
- Current and previous palliation and management of the principal diagnosis and related condition(s);
- Complications, non-related conditions, risk factors, allergies, and intolerances;
- Functional status;
- Kidney and liver function status (if/when available, to ensure safe medication dosing);
- Imminence of death;
- Chief complaint and prioritization of symptoms, including evaluation of symptom severity and burden;
- Medication profile review and reconciliation (including indication, effectiveness/ineffectiveness, side effects, dosage, drug-drug and drug-disease interactions, therapeutic duplication, need for laboratory monitoring, overall appropriateness based upon patient status, patient prognosis, medical necessity, patient/family goals of care, risk/benefit analysis, and adverse effects). Documented medications include prescription and over the counter medications, herbal remedies, and other alternative treatments related and unrelated to the patient's principal diagnosis and condition(s) that contribute to the terminal prognosis;
- Initial bereavement risk assessment of patient and family/caregiver, including social, spiritual, and cultural factors that may impact their ability to cope with the patient's death;
- Referrals to community or ancillary services;
- Military history checklist (for Veterans); and
- Changes that have occurred since the initial assessment, progress towards goals, reassessment, and response to care.

CES 1.6 The comprehensive assessment is updated as frequently as the condition of the patient requires but no less frequently than every 15 days and at the time of recertification.

CES 1.7 The comprehensive assessment includes data elements that allow for measurement of outcomes. These data elements are documented in a systematic and retrievable way for each patient and are used in individual care planning and documenting progress toward goals and outcomes, coordination of services and, in aggregate, for quality assessment/performance improvement.

Practice Examples:

- The hospice uses the military history checklist as part of the comprehensive assessment for Veterans to evaluate the impact of their military experience, identify related conditions (e.g., post-traumatic stress disorder (PTSD)), and determine if there are benefits to which the Veteran and surviving dependents may be entitled.
- The hospice has a mechanism to obtain past medical records from referral sources.
- The hospice includes assessment of common co-morbid conditions as part of the initial nursing assessment and review of all prescription, over the counter, and herbal medications. The assessment includes documentation of which conditions and medications are related to the terminal prognosis.
- The review of conditions and all medications (related and unrelated) medications informs the content of the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" form (Election statement addendum).
- The initial assessment includes documentation on the stated goals and wishes of the patient and family/caregiver.
- The initial assessment includes evidence of the discussion or confirmation of patient and family/caregiver's preferences regarding life sustaining treatments, including CPR and hospitalization. Patients that desire to avoid hospitalizations inform the care plan regarding potential need for continuous home care for symptom exacerbation.

Standard:

CES 2: The patient's goals for pain management are addressed.

CES 2.1 An initial pain assessment is completed for every patient upon admission to hospice, including severity, location, character, duration, frequency, what relieves and worsens pain, and effect on function and quality of life.

CES 2.2 Ongoing pain assessments are performed and include the use of a self-report or observational pain rating scale appropriate to the patient's cognitive and functional status and general condition.

CES 2.3 Specialized pain assessment tools are available for various populations served (e.g., pediatric, nonverbal, non-English speaking, illiterate patients, and those unable to self-report).

CES 2.4 Procedures and protocols for pain assessment and management are developed and implemented with the involvement of a clinician(s) with pain assessment and management expertise.

CES 2.5 Patients and families/caregivers are educated and trained about the importance of, barriers to, and methods of effective and safe pain management, including pain assessment and medication administration, as well as when to call hospice for unmanaged pain and/or side effects.

CES 2.6 Non-pharmacological interventions and adjuvant medications are included as pain management options as indicated.

CES 2.7 Common side effects of analgesics are anticipated, and preventive measures are implemented.

CES 2.8 Regular assessment of the current pain medication regimen and supply is made to quickly optimize pain control and avoid interruption or delay in ordering or obtaining any required analgesics, to include anticipation of increased pain as disease progresses and to plan for optimal pain control.

CES 2.9 Patients who have opioids prescribed for pain or other symptom management also have a bowel regimen or documentation why a bowel regimen is contraindicated.

Practice Examples:

- Pain assessment is documented as a distinct, easily identifiable part of the initial and subsequent assessments.
- Patients and families/caregivers identify their goals for pain management, which is included in the care plan and informs interventions related to ongoing pain assessments.
- Patient/family/caregiver instruction about the use and side effects of analgesic and adjuvant medications, non-pharmacological techniques (e.g., guided imagery, breathing techniques, energy consolidation), and expected responses to therapy is consistently and clearly documented in the patient record.
- Patients and families/caregivers are educated about the relationship between pain and psychosocial/emotional/spiritual factors that contribute to stress and end-of-life challenges.
- Specific protocols/procedures are in place for reassessing patients who rate their pain greater than the identified level the patient desires.
- Non-pharmacologic therapies for pain management including, but not limited to, radiation therapy, complementary therapies, or surgical intervention are utilized as appropriate.
- The hospice has bowel regimen protocols for patients receiving opioids.
- Staff are educated during orientation and annually on current evidence-based standards of pain management.

Standard:

CES 3: Symptoms other than pain are managed based on the patient's needs and response to treatments.

CES 3.1 Comprehensive assessments of all symptoms, other than pain, are routinely completed on every patient.

CES 3.2 Guidelines and/or protocols are developed for the assessment, screening, and management of common physical symptoms other than pain, including but not limited to:

- Dyspnea and coughing;
- Nausea and vomiting;
- Anorexia and weight loss;
- Dehydration and dry eyes/nose/mouth;
- Anxiety;
- Depression;
- Confusion;
- Delirium;
- Skin conditions, lesions, and wounds;
- Constipation and diarrhea;
- Restlessness and agitation;
- Sleep disorders;
- Mucositis;
- Edema and lymphedema, including ascites;
- Fever and infections;
- Seizures;
- Cachexia, weakness, and musculoskeletal disorders; and
- Alterations in sensation and other neurological symptoms.

CES 3.3 The hospice nurse assesses the patient's nutritional status and implements appropriate nutritional interventions as desired by the patient and as deemed appropriate regarding the patient's prognosis and medical history. If the patient's nutritional status needs are complex, a nutritionist or dietitian should assess the patient's needs and implement appropriate nutritional interventions

CES 3.4 Education and training is provided to the patient and family/caregiver about the disease process and the palliation of the patient's symptoms.

Practice Examples:

- The hospice develops educational tools to utilize in teaching patients and families/caregivers about the nutritional needs of the terminally ill, including concerns about the patient not eating or drinking and considerations related to the provision of artificial feeding.
- The hospice has resources available to educate and train staff and/or caregivers about Veteran-specific issues and symptoms related to their military service, such as post-traumatic stress disorder and spiritual or moral distress.
- The hospice has textbooks and current evidence-based educational resources available to the staff related to the palliation of symptoms.

- Routine symptom assessment includes severity, alleviating and/or exacerbating factors, and which therapies have been tried and whether those therapies have been effective.
- Specialized assessments are developed for various populations served (e.g., pediatric patients, developmentally disabled patients, homeless patients, incarcerated patients).
- The hospice has protocols for management of symptoms other than pain (e.g., dyspnea, delirium, vomiting).

Standard:

CES 4: The pharmacotherapeutic needs of patients are met while adhering to applicable state and Federal laws and regulations and accepted standards of practice.

CES 4.1 A patient-specific medication profile is maintained and continuously reviewed and updated to reconcile medications and to monitor for medication effectiveness, actual or potential medication-related adverse effects, drug-drug and drug-disease interactions, and medication duplication.

CES 4.2 A process is in place to review all prescribed and non-prescribed medications for appropriate utilization. This process includes, at a minimum, an assessment of expected treatment outcomes, dosage, frequency and route of administration, duplicative therapy, potential adverse drug reactions and side effects, and potential drug-drug and drug-disease interactions.

CES 4.3 The hospice provider reviews all prescribed, over the counter, holistic or alternative products, and any other medications for medical necessity, and the hospice physician deprescribes medications as applicable.

CES 4.4 Written policies and procedures are developed in compliance with applicable state and Federal laws and regulations governing the prescribing, dispensing, labeling, compounding, administering, transporting, delivering, tracking, controlling, and storing of all medications and biologicals.

CES 4.5 Written policies and procedures are developed to identify cost factors and guide formulary decisions for medications only after safety, efficacy, side effect profile, and therapeutic need have been established. Consideration of the use of equivalent alternative medications and therapies is incorporated into the evaluation process.

CES 4.6 Written policies and procedures are developed for the disposal of controlled medications when the patient no longer needs the medications or after the patient's death. Disposal methods follow Federal and/or state guidelines.

CES 4.7 Patients and families are informed about policies for tracking and disposing of controlled substances when treatment with a controlled substance is initiated.

CES 4.8 Pharmacy services are available twenty-four (24) hours a day, seven (7) days a week.

CES 4.9 Quantities of medications dispensed to the patient are sufficient to maximize patient comfort while minimizing the potential for error, waste, and diversion.

CES 4.10 Written policies and procedures are developed for defining, identifying, reporting, and documenting medication errors and adverse drug reactions that ensure adequate follow-up in all settings where care is delivered.

CES 4.11 Written policies and procedures are developed to describe the use of experimental medications and protocols.

CES 4.12 Written policies and procedures are developed to identify and manage potential and actual drug diversion.

CES 4.13 Patients and families/caregivers are educated on safe and effective use of medications, safe medication administration, and potential side effects and expected responses. The hospice interdisciplinary team assesses the ability of the patient and family/caregiver to safely administer and store medications.

CES 4.14 Families/caregivers are educated about safe medication disposal after the patient's death.

CES 4.15 Written policies and procedures are developed to define the appropriate use of medications that may be considered "chemical restraints." The policies and procedures include stipulations that these medications may be used only if needed to improve the patient's wellbeing or to protect them or others from harm and only when less restrictive interventions have been determined ineffective.

CES 4.16 Written policies and procedures are developed for administration and management of palliative sedation including goals of care.

CES 4.17 Written policies and procedures are developed for the identification of medications covered under the hospice benefit related to the principal diagnosis and co-morbid conditions that contribute to the terminal prognosis. The policies and procedures include provisions for coordination with pharmacies and medication plans regarding medication approvals when applicable.

CES 4.18 Written policies and procedures are developed for the identification of medications not covered under the hospice benefit and are unrelated to the principal diagnosis and co-morbid conditions that contribute to the terminal prognosis. The policies and procedures include provisions for coordination with pharmacies and medication plans regarding medication approvals when applicable.

Practice Examples:

- A pharmacist, hospice physician, or nurse practitioner reviews all medication profiles for potential medication-related effects, correct dosing, accurate and practical administration directions, drug-drug and drug-disease interactions, overall appropriateness based on patient status, patient prognosis and patient and family/caregiver goals of care, risk-benefit analysis, and duplication at the time the medication is ordered.
- The hospice nurse, hospice physician, or hospice medical director counsels the patient and family/caregiver on the discontinuation of medications, as appropriate, based on the patient's terminal prognosis and changes in status on an ongoing basis.
- The hospice has a policy for disposal of controlled substances, communication about critical medication shortages, formulary maintenance, and how to handle substitution protocols and recalled or discontinued medications.
- The hospice nurse reviews and provides a copy of the hospice's medication disposal policy for controlled drugs with the patient and family/caregiver at the time the drug is prescribed.
- The hospice nurse reviews all written medication information with the patient and family/caregiver in a manner and language of their choice. The hospice nurse ensures and documents the patient and family/caregiver understands this information.
- The hospice nurse notifies the pharmacist regarding the patient's condition and estimates the quantity of medication needed to meet the patient's needs.
- Incident reports regarding medication errors and drug diversion are completed and monitored for trends or high risk.
- The hospice nurses have access to up-to-date medication information and resources to ensure timely and safe administration of medications.

- The hospice has a policy for handling patient requests for vaccine administration.
- Hospice interdisciplinary team members educate patients and families on the use of holistic or alternative products (e.g., vitamins, herbs, homeopathy, ayurvedic, over-the-counter products, and other substances that can impact treatment and outcomes) as indicated.

Standard:

CES 5: Diagnostic services necessary for the management of symptoms and according to the patient's plan of care are provided.

CES 5.1 Lab specimens obtained by the hospice are taken only to laboratories that meet Clinical Laboratory Improvement Amendment (CLIA) and state law requirements.

CES 5.2 The hospice complies with applicable state law and secures a CLIA certificate of waiver for any waived testing performed by hospice staff.

CES 5.3 Policies and procedures address:

- Personnel requirements for performing and supervising waived testing;
- Training, orientation, and competency verification processes for staff performing waived testing;
- Specific procedures related to the waived testing; and
- Quality control checks and related recordkeeping requirements.

CES 5.4 Criteria are developed regarding the provision of laboratory, radiology, or other diagnostic assessments.

Practice Examples:

- Current competency evaluations related to instrument usage are documented on all hospice nurses performing tests such as blood glucose monitoring, pulse oximeter, Prothrombin Time Test and INR (PT/INR), etc.
- Quality control checks are performed and documented per manufacturer's instructions for diagnostic devices.
- The hospice interdisciplinary team considers information from the attending physician, accepted standards of practice related to palliative care, and patient and family/caregiver preferences when determining whether to include a specific diagnostic assessment or therapy in the patient's plan of care.

Standard:

CES 6: Therapeutic treatments and interventions are provided for the management of symptoms according to the patient's plan of care.

CES 6.1 Services such as physical therapy, occupational therapy, speech therapy, psychosocial counseling, pharmacological counseling, and nutritional counseling are available and utilized to help the patient reach optimal functioning as permitted by patient status and goals for care.

CES 6.2 Criteria regarding the provision of treatment such as radiation, chemotherapy, pharmacotherapy, and other therapies are developed for palliation of symptoms and applied on a case-by-case basis.

CES 6.3 Indicated complementary and non-pharmacologic therapies are offered as an adjunct to promote quality of life depending on patient goals and preferences.

Practice Examples:

- The hospice provides complementary therapies such as expressive therapy (e.g., art therapy and music therapy), massage therapy, acupuncture, aromatherapy, reflexology, and healing touch.
- Palliative radiation therapy or other palliative therapies are considered for treatment of symptoms and to improve the patient's quality of life.
- The hospice has contracts with oncology radiology for the provision of palliative radiation therapy as appropriate to relieve symptoms secondary to tumor burden.

Standard:

CES 7: Interventions to assist the patient and family/caregiver in meeting preferences within a changing environment or life circumstances are based on the comprehensive assessment performed at the time of admission and repeated throughout the course of care.

CES 7.1 The comprehensive assessment includes an evaluation of social, practical, and legal needs of the patient and family/caregiver in home, work, and school settings, and, if applicable, the patient's military history.

CES 7.2 The comprehensive assessment considers the patient's cognitive ability and preferred style of communicating feelings and expressing emotions, thoughts, and needs.

CES 7.3 The comprehensive assessment explores the patient's way of finding meaning in their experience within the context of their life and social environment (e.g., self, family, friends, groups and affiliations, and other supportive relationships including religious and spiritual beliefs).

CES 7.4 Comprehensive assessment includes screening for all patients related to suicidal ideation.

CES 7.5 Policies and procedures include planning and intervention when the patient expresses suicidal ideation.

CES 7.6 Patient coping is assessed and addressed by the hospice interdisciplinary team and include at a minimum:

- Access to adequate and accurate information related to illness progression, care, and outcomes;
- Access to adequate social and emotional support;
- Access to spiritual or philosophical support;
- Change in family roles or dynamics (e.g., related to the loss of physical abilities and function, employment, hobbies, lifestyle);
- Changes in finances or resources;
- Communication abilities and challenges;
- Risk factors such as behavioral health or substance abuse;
- Ability to fulfill desired sexual expression;
- Suicidal ideation;
- Signs of abuse or neglect; and
- Care cost or other care-related financial concerns.

Practice Examples:

- The hospice documents patient conversations about suicidal thoughts and implements protocols for intervention.
- Psychosocial assessment tools allow for assessment related to end of life as well as issues identified as important and relevant by the patient, family, or caregiver.
- Patient and family/caregiver educational materials and support are delivered in a manner and language of choice. Materials may include information about the psychological aspects of a terminal illness, grief, and loss.
- The psychosocial evaluation includes issues related to military service, if applicable, for which the hospice provides support.
- Patient and family/caregiver concerns about cost of care are addressed and managed.
- The hospice explains how Death with Dignity or Physician Assisted Death (PAD) per state specific regulations impacts the patient's hospice care.

Standard:

CES 8: Services continue without interruption whenever there is a change in the patient's care setting.

CES 8.1 Care is provided in the setting designated by the patient and family/caregiver as the patient's place of residence.

CES 8.2 Access to all levels of care is provided. General inpatient care (GIP) and continuous home care (CHC) are available and utilized as necessary for pain control or management of acute symptoms that require a greater intensity of care than can be provided under routine home care. Respite care is available and utilized to relieve family members or other persons who are caring for the patient.

CES 8.3 The hospice collaborates with other organizations, service providers, and individuals involved in the provision of care.

CES 8.4 When services are not provided directly by the hospice, written contracts exist to define the services provided by both the hospice and the contracted provider. These contracts define care delivery to assure that contracted services are consistent with hospice standards and care is provided in accordance with the hospice plan of care. Written agreements assure that the hospice retains overall responsibility for managing the patient's plan of care.

CES 8.5 Care provided by the hospice in a contracted facility adheres to the same:

- Standards of care;
- Intensity; and
- Core and other services to meet the plan of care as provided to patients in their place of residence.

CES 8.6 The hospice contracts for inpatient care specify that:

- The hospice provides a copy of the patient's plan of care and specifies the inpatient services to be provided;
- The inpatient provider agrees to abide by the hospice's patient care protocols;
- The clinical record includes a record of all patient care services;

- A discharge summary and, if requested, a copy of the clinical record is provided to the hospice;
- The parties responsible for the implementation of the provisions in the agreement are identified;
- The hospice provides appropriate training for facility staff that provides care under the agreement;
- The hospice assumes overall management for the terminal illness in coordination with all other providers;
- All inpatient care services must be authorized by the hospice and delivered in accordance with the plan of care; and
- Timely communication occurs between the hospice and the facility, including regarding clinical information relevant to the plan of care.

Practice Examples:

- Utilization review processes monitor care in all care settings to assure that the scope of services meet identified needs of patients and families including, but not limited to:
 - Patient services by discipline providing the services;
 - Levels of care;
 - After hours care and support; and
 - Bereavement care.
- The hospice has a formal relationship with the Department of Veterans Affairs (VA) for care provided to Veterans in the community if a VA facility is present within the hospice's service area. The formal relationship includes coordinating care with the appropriate VA facility across care settings, communicating with VA staff regarding the care plan, and notifying VA staff at the time of the Veteran's death or discharge.
- In coordinating services with a hospice Pharmacy Benefit Manager (PBM), the hospice ensures accurate communication regarding the patient's location and level of care to optimize medication dispensing, billing, and when applicable, delivery or shipping.
- If coordinating services with a Medicare Part D plan sponsor, the hospice coordinates any prior authorization process required by the Medicare Part D plan sponsor to ensure appropriate billing to the hospice for medications related to the terminal diagnosis and related conditions and billing to the Medicare Part D plan sponsor for unrelated medications.
- Contracted providers may participate in performance improvement activities related to their provision of care and services.
- The hospice has a mechanism to record, address, and resolve complaints related to contracted providers.
- The hospice evaluates patient satisfaction with services provided by contracted services (e.g., Durable Medical Equipment (DME), pharmacy).

Standard:

CES 9: Transfers, discharges, revocations, and changes in levels/setting of care are planned and managed in a manner that assures coordination and continuity of care for patients, families/caregivers, and service providers.

CES 9.1 The hospice has written policies and procedures pertaining to transfer, discharge, and revocation, which include criteria for referral or transfer when the hospice is no longer the appropriate provider of care.

CES 9.2 When provision of care in the patient's place of residence is no longer feasible, the hospice has standard processes that assure a well-coordinated transition to another setting where hospice care can be provided.

CES 9.3 Education is provided by the hospice to the receiving care provider regarding the plan of care whenever there are changes in the patient's care setting.

CES 9.4 Transfer, discharge, revocation, and referral practices include:

- A process for ongoing evaluation of the patient's status and eligibility for hospice care;
- Interdisciplinary discharge planning that addresses the patient and family/caregiver's needs and goals;
- A coordinated transition process across all involved providers;
- Facilitation of a planned, well-coordinated, and effective transition for the patient and family/caregiver;
- A mechanism for follow-up communications with the hospice as needed;
- Copies of a discharge summary, including summary of treatments, allergies, symptoms, pain management, medication summary/profile, current plan of care, recent physician orders, and other relevant documentation, are sent to the attending physician and receiving care provider upon revocation or discharge;
- Copies of patient transfer request, including the most recent patient specific hospice plan of care, hospice election statement and the Patient Notification of Hospice Non-Covered Items, Services, and Drugs form (election statement addendum), any advance directives specific to each patient, physician certification and recertification of the terminal illness specific to each patient, names and contact information for hospice personnel involved in hospice care of each patient, hospice medication profile specific to each patient, hospice physician and attending physician (if any) orders specific to each patient, clinical information from non-hospice providers, and copies of advance beneficiary notice (ABN) forms.
- Compliance with regulatory requirements for issuing the correct notification form when a patient is discharged from hospice care because of ineligibility (Notice of Medicare Provider Non-Coverage/NOMNC) or services are provided that Medicare is not expected to cover (Advance Beneficiary Notice of Non-Coverage/ABN).

Practice Examples:

- The hospice interdisciplinary team periodically evaluates the status of all patients for continuing eligibility for hospice services.
- A step-by-step plan for discharges, revocations, and changes in levels/setting of care is developed by the hospice team to ensure coordination of care.
- The hospice ensures that required Medicare processes for discharge, including issuance of the Notice of Medicare Non-Coverage (NOMNC) and Advance Beneficiary Notice (ABN) documents, are provided to the appropriate parties and copies are in the medical record.
- The hospice coordinates with the primary care provider to ensure no disruption in continued use of necessary durable medical equipment upon hospice discharge.

Standard:

CES 10: The hospice develops, implements, and evaluates a plan for environmental safety and security.

CES 10.1 The hospice develops, implements, and evaluates a plan that addresses:

- Environmental safety and security;
- Staff safety and security;
- Equipment safety and security; and
- Patient and family/caregiver safety and security.

CES 10.2 The hospice provides education on staff safety and security annually and during new employee and volunteer orientation based on need and changes in policies and procedures. Staff safety and security education includes:

- Personal safety during travel in any setting;
- Personal safety in any patient care setting;
- Personal safety in the organization setting;
- General and personal safety and security measures;
- Policies and procedures related to unsafe situations;
- Physical safety (e.g., body mechanics and back safety);
- Occupational Safety and Health Administration (OSHA) and National Institute for Occupational Safety and Health (NIOSH) requirements as related to safety in the workplace; and
- Centers for Disease Control and Prevention (CDC), Americans with Disabilities Act (ADA), state, and local regulations.

CES 10.3 The hospice develops, implements, and evaluates a plan that addresses the safety of patients and families and includes:

- A safety assessment of each home environment, which is adapted for the patient's age and risk for falls;
- Appropriate teaching resources related to safety issues;
- Implementation and documentation of interventions directed toward eliminating or minimizing safety concerns identified in the patient's environment; and
- Ongoing assessment of patient functional capabilities and the adequacy of family caregivers as well as development of a plan for provision of care that ensures the patient's safety and addresses changing care needs.

Practice Examples:

- The hospice has a written policy that describes actions to be taken when employees or volunteers find themselves in unsafe situations.
- The hospice provides an annual safety education program for all staff and volunteers.
- The hospice makes teaching materials available to patients and families related to safety in the home.
- The assessment of each hospice patient includes an evaluation of the safety of the home environment with special attention paid to oxygen safety and storage.
- The initial assessment of each hospice patient includes evaluation of current need for caregivers, projected need as the patient's illness progresses, and development of a plan for provision of care as the patient's care needs change.
- The hospice references Occupational Safety and Health Administration (OSHA) and National Institute for Occupational Safety and Health (NIOSH) standards regarding parameters for lifting.
- The hospice uses needleless systems and sharps disposal containers to prevent needle stick injury.
- The hospice uses safe medication disposal systems and/or reconciliation of wasted controlled substances in accordance with state and Federal law and investigates suspected drug diversion.
- The hospice appoints a safety (or like purpose) committee and/or safety officer.
- The hospice interdisciplinary team checks for weapons in the patient's home and develops a plan with the patient and family/caregiver for safety.

- The hospice develops staff education related to extreme weather situations and how to respond appropriately.
- The hospice is sensitive to perceived safety issues of staff related to diversity, race, and ethnicity microaggressions.

Standard:

CES 11: The hospice develops, implements, and evaluates a plan for emergency preparedness, which includes the development of policies and procedures, a communication plan, and training and testing programs. The plan is rehearsed annually.

CES 11.1 The hospice performs facility-based and community-based risk assessments, utilizing an all-hazards approach to determine areas of vulnerability for emergency response.

CES 11.2 The hospice has a written emergency preparedness plan that provides for the continuation of services in the event of an emergency. The emergency preparedness plan includes at a minimum:

- Policies and procedures that address staffing, provision of patient services, evacuation, sheltering in place, safeguard of supplies, maintenance of clinical records, and collaboration with other community providers;
- Strategies for addressing emergency events identified by the hazard vulnerability assessment;
- A plan for the management of consequences from power failures, natural disasters, infection, and other emergencies that would affect the hospice's ability to provide care;
- The types of services the hospice can provide in an emergency;
- Strategies for ensuring continuity of operations, including delegations of authority and succession plans;
- Processes for cooperation and collaboration with local, tribal, regional, state, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation;
- Documentation of collaboration and participation with local, tribal, regional, state, or Federal emergency preparedness officials, when applicable, in planning efforts;
- The development of arrangements with other hospices and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to hospice patients; and
- The development of a succession of leadership and decision-making authority structure for continuity of hospice operations (as part of emergency preparedness plan) and includes in new hire and ongoing staff education.

CES 11.3 The hospice develops and maintains a communication plan that is updated annually. The communication plan includes at a minimum:

- Contact information (primary and alternate) for hospice staff, contractors, and Federal, state, tribal, regional, and local emergency preparedness staff;
- A process for sharing hospice patient information and clinical documentation, as necessary, with other health care providers to maintain continuity of care;
- A process to furnish and disclose information about the general condition and location of patients under a hospice's care as permitted under the Health Insurance Portability and Accountability Act (HIPAA) in the event of an evacuation; and
- A process to provide information about a hospice's inpatient unit occupancy, needs, and help to emergency preparedness officials.

CES 11.4 Training and testing on the hospice's emergency preparedness plan, communication plan, and related policies and procedures are provided to all new and existing hospice employees and individuals providing services under a contractual arrangement with the hospice at least annually. The training and testing program includes at a minimum:

- Staff knowledge of emergency procedures;
- Documentation of all emergency preparedness training;
- Exercises to test the emergency plan that include participation in a full-scale exercise that is community or facility based, as well as facilitation of an additional activity that may include a second full-scale exercise or a tabletop exercise; and
- Documentation of testing and after-action review (AAR).

CES 11.5 The hospice is integrated into the broader community network and is prepared to respond to broader community needs that result from a natural or civil disaster (e.g., relocation options for patients, requests for bereavement services, increased referrals).

Practice Examples:

- The hospice creates and regularly updates a mass notification system and/or telephone tree, using mobile telephones as necessary, to facilitate communication with the staff during an emergency.
- The hospice reviews the emergency preparedness plan with all new employees, volunteers, and contracted staff during initial orientation and annually thereafter.
- The hospice considers preparation for multiple emergency events (e.g., multiple storms or extended utility loss).
- The hospice has an internal plan related to its involvement in the greater community related to its role in response to a natural or civil disaster.
- The hospice completes a debriefing after any activation of the emergency preparedness plan to assess the need for revision to the plan for increased effectiveness in future events.
- The hospice has a crisis communication plan for communicating internally with staff, volunteers and patients/families, and externally with the media.
- The hospice participates annually in a state/regional wide or country-wide drill that includes triaging patient needs in an emergency.

Standard:

CES 12: The hospice develops, implements, and evaluates a plan for the management of infectious and hazardous materials and waste.

CES 12.1 The hospice develops and implements a written plan that addresses:

- Identification of infectious and hazardous materials and waste, including hazardous medications;
- Proper storage, transportation, and disposal of infectious and hazardous materials and waste;
- Compliance with all applicable laws and regulations related to infectious and hazardous materials and waste;
- Precautions, procedures, and personal protective equipment (PPE) to be utilized when handling infectious and hazardous materials and waste;
- Employees' right to know about infectious and hazardous materials and waste (e.g., availability of Safety Data Sheets (SDS)); and
- How staff is educated on the above.

Practice Examples:

- Safety Data Sheets (SDS) are available for all hazardous materials used by staff in performing their duties and responsibilities.
- Hazardous materials and medications (e.g., finasteride, hydroxyurea) are appropriately labeled.
- Sharps containers are clearly labeled as "hazardous waste" or color-coded and are properly disposed of according to hospice policy.
- Specimens are safely and securely collected, handled, labeled, and transported to the diagnostic laboratory.
- All patient clinical records include documentation of known infections.
- All clinicians receive education related to management of infections and handling hazardous materials and waste annually. The hospice tracks and documents staff participation in the education program.

Standard:

CES 13: The hospice develops and implements an infection control program that is designed to identify and decrease the risks of infection for staff, patients, and families; to monitor trends and prioritization of infection control risks; and to decrease the rates of infection.

CES 13.1 The hospice has an infection control program that reflects standard infection control policies and practice and includes the following components:

- Educating patients, family members, and other caregivers regarding the prevention and control of infection in a manner and language that they can understand;
- Documenting infection control education to patients, family members, and other caregivers including hand and respiratory hygiene and cough etiquette.
- Developing, reviewing periodically, and updating of policies and procedures related to infection control;
- Educating staff, volunteers, and contract staff related to infection control practices including routes of transmission of microorganisms and the importance of effective hand washing technique, potential for exposure to infection, and follow-up to an exposure;
- Monitoring and reporting employee health and the provision of related services including vaccinations such as COVID-19, influenza, and hepatitis B to the state public health department as required per state law;
- Designating a staff member responsible for implementation and oversight of the infection control program;
- Establishing a system for communicating the components of the infection control program with employees and volunteers as well as referring and receiving organizations;
- Prioritizing infection control risks as part of infection control plan;
- Establishing standard levels for PPE, monitoring burn rate, and managing utilization and distribution (CDC's PPE Burn Rate Calculator); and
- Implementing Federal and state specific infection control requirements (e.g., COVID-19 testing).

CES 13.2 The hospice staff reports patient, employee, and volunteer infections as identified in the hospice surveillance policies and in accordance with state reportable disease requirements.

CES 13.3 The hospice collects defined surveillance data as part of the infection control program and takes appropriate corrective actions based on analysis of the data. Infection control data collection may include:

- Identification of targeted infections, unusual or undesirable trends, and factors contributing to such trends as part of QAPI program;
- Results of monitoring staff for compliance with policies and procedures;
- Reportable employee illnesses and infections including trends and correlation with patient infections; and
- Unanticipated deaths related to healthcare associated infections and conforming to the hospice's definition of a sentinel or adverse event.

Practice Examples:

- Performance evaluations of staff who provide direct patient care include an assessment of their knowledge and practice of infection prevention and control.
- The hospice has policies and procedures describing the follow-up actions to be taken in the event of an occupational exposure to blood borne or airborne pathogens.
- Employee illnesses and infections are reported and analyzed for relationships to infections among patients and other employees.
- When an infection is present, appropriate actions, including applicable isolation precautions, are taken to control its spread among staff and patients (e.g., providing written instructions via teaching sheets or safety booklets in addition to verbal instruction).
- Infection control education is provided to all hospice staff on hire, annually, and as conditions warrant.
- The hospice provides instruction (verbal and written) to patients and families regarding standard precautions and the prevention and control of infection in a manner and language they can understand.
- The hospice has written policies and procedures that establish and promote the communication and collaboration of infectious disease reporting and tracking with local, state, and Federal agencies.
- The hospice has a mechanism to track infections to monitor for quality assurance and performance improvement opportunities.

Standard:

CES 14: The hospice's infection control program conforms to the guidelines set by Federal/ state government agencies, professional associations, and applicable laws and regulations.

CES 14.1 The hospice has a written blood borne pathogen exposure control plan, pandemic measures, and a respiratory protection plan that are reviewed with all staff and volunteers during orientation and on an annual basis.

CES 14.2 The hospice has developed a policy and procedure for dealing with pandemics/epidemics. The plan includes but is not limited to:

- Patient management strategies:
 - Prolonged isolation;
 - Sanitation and hygiene;
 - Social distancing;
 - Provision of virtual patient care vs. in-person visits;

- Inform contracted vendors about presence of infectious disease;
- Handling corpses and notifying funeral homes of patient with infectious disease;
- Coordination with other community agencies; and
- Staff protection and management strategies:
 - PPE;
 - Prolonged work from home;
 - Facilitation of virtual employee meetings;
 - Advocacy for staff vaccines;
 - Assessment and modification of workspace for employee safety; and
 - Crises staffing plan

CES 14.3 The hospice has policies and procedures to ensure all staff are fully vaccinated for COVID-19. Specifically:

- Staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19.
 - A primary vaccination series for COVID-19 is defined as the administration of a single-dose vaccine or the administration of all required doses of a multi-dose vaccine.
- Policies and procedures must apply to the following hospice staff, who provide any care, treatment, or other services for the hospice and/or its patients regardless of clinical responsibility or patient contact:
 - Hospice employees;
 - Licensed practitioners;
 - Students, trainees, and volunteers; and
 - Individuals who provide care, treatment, or other services for the hospice and/or its patients, under contract or by other arrangement.
- Policies and procedures specify they do not apply to the following hospice staff:
 - Staff who exclusively provide telehealth or telemedicine services outside of the settings where hospice services are provided to patients and who do not have any direct contact with patients, families, and caregivers; and
 - Staff who provide support services for the hospice that are performed exclusively outside of the settings where hospice services are provided to patients and who do not have any direct contact with patients, families, and caregivers.
- Policies and procedures include, at a minimum, the following that apply to staff outlined in the second bullet of CES 14.3 (i.e., hospice employees; licensed practitioners; students, trainees, and volunteers; and individuals who provide care, treatment, or other services for the hospice and/or its patients, under contract or by other arrangement):
 - A process for ensuring all staff (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the hospice and/or its patients;
 - A process for ensuring that all staff are fully vaccinated, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
 - A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
 - A process for tracking and securely documenting the COVID-19 vaccination status of all staff;

- A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
- A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
- A process for tracking and securely documenting information provided by those staff who have requested, and for whom the hospice has granted, an exemption from the staff COVID-19 vaccination requirements;
- A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable state and local laws, and for further ensuring that such documentation contains:
 - » All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
 - » A statement by the authenticating practitioner recommending that the staff member be exempted from the hospice's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
- A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
- Contingency plans for staff who are not fully vaccinated for COVID-19.

Practice Examples:

- The hospice monitors Department of Health reports of infection in the community.
- The hospice provides both fit testing and N-95 masks for staff that provide direct care to patients who need respiratory droplet precautions.
- All clinical staff have an adequate supply of personal protective equipment.
- The hospice has a process for maintaining current knowledge of potential pandemics/epidemics.
- All staff receives training related to COVID-19 vaccination requirements.
- COVID-19 tracking is part of a hospice organization's QAPI program.
- The hospice works with community partners to ensure COVID-19 vaccination requirements are met in all care environments that the hospice provides care.

For more information, please refer to the CDC's [website](#).

Standard:

CES 15: The hospice infection control program is monitored, reviewed, evaluated, and updated at least annually.

CES 15.1 A summary of all infection control activities performed, surveillance data collected, risk assessment, and actions taken related to the data aggregation and analysis is submitted to the hospice's administrative leadership and reviewed at least annually.

CES 15.2 The infection control program includes objective and systematic measurement, monitoring, and evaluation of services and implementation of quality improvement activities within an organization's QAPI program based upon the findings. The program uses quantifiable measures to establish and evaluate compliance with infection program standards.

Practice Examples:

- The hospice's performance improvement committee regularly reviews reports and data related to infection control activities.
- Maintenance of PPE minimum par levels and assessment of burn rate.
- At least one aspect of care related to infection control is evaluated annually (e.g., COVID-19 infection, Tuberculin skin test conversions, catheter-related infections, employee illnesses) with the goal of improvement.
- The hospice has established an influenza prevention program for patients and staff.
- The hospice utilizes NHPCO's Measures of Excellence (MOE) to report infections quarterly and benchmark infection data nationally and by state.

Standard:

CES 16: Seclusion and restraints may only be utilized if needed to improve the patient's wellbeing or protect the patient or others from harm and only when less restrictive interventions have been determined to be ineffective.

CES 16.1 The hospice has written policies and procedures for implementation of seclusion and restraints, including but not limited to:

- Physician order;
- Specification of purposes for restraint;
- Definition of restrictive devices;
- Education of patient and family/caregiver; and
- Frequency of monitoring.

CES 16.2 If seclusion and restraints may be used in the hospice's inpatient facility, staff who provide direct patient care receive training and education in the proper use of seclusion and restraint application and techniques. Staff must also hold current certification in cardiopulmonary resuscitation (CPR). (See Appendix 1, Hospice Inpatient Facility for additional standards for utilization of seclusion and restraints.)

CES 16.3 Hospice staff who provide direct patient care receive training and education in alternative methods for handling situations where seclusion and restraints customarily have been used.

CES 16.4 The hospice must report any serious injury and/or death related to the use of restraints to local, state, and Federal regulatory agencies within the required timeframe.

CES 16.5 Hospice inpatient facilities develop a policy/procedure for "restraint and seclusion free" care which includes processes if those measures are required for a patient.

Practice Examples:

- The hospice's seclusion and restraint policy and procedures specify what medications and restrictive devices are considered restraints within the hospice setting.
- Medications ordered for hospice patients that are considered chemical restraints in other settings (e.g., nursing homes) have clearly defined symptom management protocols that reflect the indications for use.
- The hospice informs the family/caregiver prior to initiating restraints.

Standard:

CES 17: The hospice has a written plan for fire safety and prevention within the hospice's environments and patient settings including:

- Evacuation procedures and escape routes;
- Management of fire extinguishers;
- Protection of staff, visitors, and property from fire and smoke;
- Policies for using smoking materials in all settings;
- Policies for the management of highly combustible materials and/or equipment;
- Fire equipment maintenance policies/procedures; and
- Documented regularly scheduled fire drills

CES 17.1 The hospice provides staff education related to fire safety, prevention, and response to a fire in all settings at least annually.

CES 17.2 The hospice develops, implements, and evaluates a plan for fire prevention in the patient's environment that includes:

- Assessment of fire hazards;
- Implementation and documentation of actions taken related to fire prevention;
- Patient and family/caregiver education related to fire prevention (e.g., use of smoke detectors, oxygen safety and risky behaviors); and
- Patient and family/caregiver response to a fire in the home, including escape routes.

Practice Examples:

- Fire safety is included in new employee and volunteer orientation.
- Staff receives annual in-service education on fire safety including use of fire extinguisher.
- The hospice regularly reviews oxygen safety with patients, families, and other caregivers when oxygen is in use in the home. The hospice provider collaborates with the DME vendor related to oxygen safety protocols.

Standard:

CES 18: The hospice develops, implements, and periodically reviews a plan for continued operations in the event of interrupted communication and/or utility systems.

CES 18.1 The hospice develops, implements, and evaluates a plan for utility systems management within the hospice that provides for a safe and comfortable environment and communication system, including but not limited to:

- Computer and electronic medical record (EMR) backup;
- Telephone backup systems;
- Utility systems failure (e.g., electrical system); and
- Communication systems failure.

CES 18.2 The hospice addresses patient safety and continuation of hospice care in the patient's environment to include:

- Assessing utility requirements for medical equipment used in patient care;
- Assessing environmental requirements for medical equipment;
- Assessing safety issues relating to electrical outlets, grounding, circuit overload, and other electrical system potential hazardous areas;
- Providing education for all patients, family members, caregivers, and employees on the safe use of medical equipment per equipment manufacturing requirements;
- Providing education on methods of contacting the hospice during communication systems failure; and
- Identifying community resources to provide utility services needed for patient comfort as indicated.

Practice Examples:

- Patients and families/caregivers receive verbal instruction and related written instructional materials for any medical equipment used in the home in a format and language they can understand.
- Patients utilizing oxygen in the home have a backup source of oxygen in case of a system failure.
- The hospice ensures that patients are on a utility priority list in the event of a power outage.
- The hospice ensures that patients have adequate warmth or cooling, light, etc. to meet basic comfort needs.

Standard:

CES 19: The hospice ensures that medications and nutritional products are properly transported, managed, handled, stored, prepared, and administered.

CES 19.1 The hospice has policies and procedures for proper storage and handling of medications and nutritional products in all patient settings, including:

- Securing all controlled medications in accordance with law and regulation to prevent diversion;
- Safe storage (e.g., proper temperature, attention to expiration dates, controlled ventilation, humidity) in accordance with manufacture's recommendations;
- Separate storage of medications for internal use and medications intended for external use; and
- Proper labeling (e.g., medications are stored according to the label, package insert, or other written instructions).

CES 19.2 Hospice staff instructs patients and families on the correct preparation and administration of medications and nutritional products in the patient's home.

Practice Examples:

- Expired medications and nutritional products are disposed of promptly and properly following applicable regulatory guidelines.
- All medications and nutritional products are adequately labeled.
- The family is instructed to keep medication out of the reach of children and to track when medication is administered to prevent a medication error.
- The hospice has a tracking system to assure that medications are delivered safely and timely.
- The hospice incorporates methods to assure adherence to medication administration schedules based on the prescribed dosing frequency.
- The hospice educates patients and caregivers on proper medication dosing and routes of administration.
- The hospice contracts with pharmacies that comply with local, state, and Federal laws related to the proper management, handling, storage, preparation, and transportation of medications and nutritional products.
- When there is a concern of possible drug diversion the patient's home the hospice takes steps to safeguard medications, including but not limited to:
 - Initiating a controlled substance agreement;
 - Placing a lockbox in the home; limiting the quantity of medication dispensed;
 - Altering the route of medication administration; considering alternate locations for medication storage;
 - Increasing visit frequency; and
 - Implementing and documenting medication counts at each visit.

Standard:

CES 20: The hospice develops, implements, and evaluates a plan for reporting, monitoring, and following up on all incidents.

CES 20.1 The hospice has written policies and procedures that define reportable incidents and a mechanism for reporting, following up, and tracking incidents that include but are not limited to:

- Adverse outcomes including medication reactions and complications of treatment;
- Staff endangerment or injury;
- Patient or family/caregiver injury including falls;
- Theft or damage to property;
- Motor vehicle accidents incurred when conducting hospice business;
- Equipment or mechanical device failure or user errors;
- Problems related to the safe handling and use of controlled substances;
- Unusual occurrences;
- Patient-related suicide or homicide threats, attempts, or completion;
- Unusual symptom clusters in a family or community;
- Harassment or sexual abuse;
- Patient abuse or neglect;
- Medication diversion;
- Mandated state reported incidents;

- Delay of patient care (timeliness of care); and
- Vendor service and quality issues.

CES 20.2 The hospice designates oversight responsibility for:

- Investigating all incidents;
- Taking follow-up actions as necessary;
- Initiate root cause analysis as needed;
- Aggregating incident data to monitor for trends; and
- Utilizing the data for risk management and quality improvement.

CES 20.3 The hospice ensures adequate record keeping and reporting of incidents in compliance with Federal and state regulations, and requirements from accreditation organizations.

Practice Examples:

- The hospice has a process for reporting and documenting incidents.
- Incidents involving a premature death, unexpected or accidental death, or a suicide will receive an intensive evaluation to identify the root cause and mitigate a future risk.
- Serious adverse events are reported to state and/or Federal agencies according to abuse/neglect laws, HIPAA regulations, accrediting agency standards, or other laws and regulations.
- Staff members are free from reprisal for reporting incidents.
- Staff is educated related to mandated reporting requirements at new hire orientation and at least annually.
- The hospice participates in the NHPCO MOE to report falls and medication errors quarterly to benchmark their data with other hospices at a national and state level.

Standard:

CES 21: The hospice provides for the safe and effective management of medical equipment including delivery, setup, maintenance, and training of regular and contracted staff, patients, and families/caregivers.

CES 21.1 When the hospice provides medical equipment, directly or by contract, a system is in place to assure the quality, functionality, and cleanliness of the medical equipment.

CES 21.2 When the hospice provides medical equipment, directly or by contract, a system is in place to ensure effective selection, delivery, setup, maintenance, and instruction in use of the equipment.

CES 21.3 The hospice ensures that emergency maintenance, replacement, or backup for medical equipment is available twenty-four (24) hours a day, seven (7) days a week.

CES 21.4 The hospice ensures that equipment hazards, defects, and recalls are appropriately addressed and reported as required by the Safe Medical Device Act.

CES 21.5 The hospice complies with manufacturer's instructions, as well as state and local laws, regarding the use of medical equipment.

CES 21.6 If the hospice contracts for durable medical equipment, the hospice must contract with a DME-accredited company.

CES 21.7 Any equipment owned by the hospice for staff use is checked per manufacturer recommendations or replaced as necessary (e.g., blood pressure cuffs, glucose monitoring equipment).

CES 21.8 The hospice integrates DME management into the emergency preparedness plan.

Practice Examples:

- The hospice has a procedure for reporting and responding to defective medical equipment and equipment recalls.
- The hospice ensures that patients have an adequate backup source for oxygen in case of a power failure or other emergency event.
- When equipment is delivered to the patient's home, the patient and family/caregiver receive written and verbal information on how to operate and troubleshoot the medical equipment in a manner and language they can understand.
- When a contracted provider supplies medical equipment, the contracted provider's performance is monitored and evaluated.
- The hospice orders equipment consistent with state law (e.g., bedrails).



Inclusion and Access (IA)

Inclusion and Access (IA)

Principles

Promoting inclusiveness in the community by ensuring that all people regardless of race, ethnicity, color, religion, gender identity, disability, sexual orientation, age, disease, or other characteristics have access to the hospice's programs and services.

Standard:

IA 1: The hospice ensures patient care and services provided are responsive to and welcoming of the needs of the population served.

IA 1.1 The organizational leaders periodically evaluate, review, and revise the hospice's services to meet the community's needs. The assessment should include evaluation of the community's race, ethnicity, language, communication preferences, education access, healthcare access, economic stability, social and community context, neighborhood and built environment, and related market penetration.

IA 1.2 The hospice has established criteria that clearly identify and effectively communicates the requirements for admission to--and discharge from--hospice care.

IA 1.3 Access to care, based on the needs of the patient and family/caregiver, is provided without regard to race, national origin, age, gender identity, religion, creed, diagnosis, disability, sexual orientation, place of residence within the hospice's service area, source of payment, or the ability to pay for services.

IA 1.4 The hospice's informational initiatives describe the organization's principles and approach to provision of care, include details on all services offered, and are adapted for specific populations and top languages spoken in their service area. Information sources include literature, website, and communication through social media.

IA 1.5 The hospice uses community-specific communication methods to reach the intended population(s).

IA 1.6 The hospice considers utilizing multiple locations, if feasible, to ensure service provision is as timely, effective, and inclusive as possible.

IA 1.7 The hospice makes use of innovative technologies and social media as appropriate to address challenges related to care delivery across diverse patient populations and demographics, such as provision of care in remote locations and on-site caregivers being unavailable.

Practice Examples:

- The hospice's strategic plan contains goals and strategies designed to meet community needs.
- The hospice implements performance improvement projects aimed at improving the hospice's ability to meet the community's needs.

- Needs specific to the demographic characteristics of the family caregiver population (e.g., adult children, older spouses) served by the hospice are taken into consideration when developing informational materials.
- Brochures and other informational materials describing the services the hospice provides are available in English as well as in other languages that are prevalent in the community. The materials include culturally relevant content, are written at appropriate literacy/health literacy levels, and address specific cultural sensitivities related to death and dying and family caregiving.
- Photographs used in the hospice's brochures reflect the ethnic and racial diversity of the community it serves.
- Information that specifies the procedures and criteria for admission to hospice care is distributed to referring and non-referring physicians.
- Contacts are made with specialty physicians (e.g., cardiovascular, pulmonary, neurology, nephrology, gerontology, family, pediatric) to facilitate the appropriate referral of patients with a non-cancer diagnosis.
- The hospice collaborates with disease-specific organizations to identify ways to facilitate timely access to care for eligible patients.
- The hospice explores Health Insurance Portability and Accountability Act (HIPAA) compliant telehealth options such as video conferencing, sensors to monitor patient falls and elopement from supervised care, cardiopulmonary monitors, and robotic telepresence options.
- The hospice utilizes a system and appropriate technology to communicate with deaf and hard-of-hearing patients.
- The hospice uses a variety of marketing methods that reflect the preferences and habits of specific target audiences (e.g., information directed toward parents of young children is disseminated through social media).
- Education for working family caregivers is offered at the workplace and information sessions are recorded as podcasts to increase access.
- The hospice provides core services to all patients, regardless of ability to pay.

Standard:

IA 2: The hospice facilitates access to care by providing services as well as clinical and management staff that are sensitive to the culturally diverse needs of the community it serves.

IA 2.1 Hospice staff, volunteer orientation, and in-service education programs include training that reflects the cultural diversity of the community served by the hospice and includes specific training related to cultural competency, implicit bias, and microaggression.

IA 2.2 Information regarding the provision of services specific to the cultural diversity of the population served is included in the annual program evaluation and contains assessment of race and ethnic data in the provider's completed hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys.

IA 2.3 The hospice disseminates accessible information to the community and referral sources about the services offered, who qualifies for services, how services may be requested or obtained, and payment for services (see [NHPCO's Diversity Resources](#)).

IA 2.4 The hospice arranges for interpreter services and culturally sensitive information in the preferred language of the patient/family/caregiver.

IA 2.5 Collection of cultural information and social determinants of health is part of the comprehensive assessment, and includes, but is not limited to: primary language; income; education and healthcare access; food security; preferences for support services; and funeral/burial practices (see [CDC Social Determinants of Health](#)).

Practice Examples:

- The cultural, ethnic, and racial composition of the population in the hospice's service area is represented in the composition of the hospice staff and volunteer pool.
- The hospice annually assesses the cultural competency of clinical staff. Cultural competence requires organizations and their personnel to:
 - Value diversity;
 - Assess themselves;
 - Manage the dynamics of difference;
 - Acquire and institutionalize cultural knowledge; and
 - Adapt to diversity and the cultural contexts of individuals and communities served.
- The hospice intake staff receives training in cultural competence to enable them to respond appropriately when talking with individuals from various cultural and ethnic backgrounds.

Standard:

IA 3: A periodic community needs assessment that examines both private and public resources—with special attention to securing access to care for underserved populations in the community—informs the development and implementation of hospice services.

IA 3.1 A periodic community-wide needs assessment is performed by or is available to the hospice.

IA 3.2 The hospice analyzes data from the needs assessment and develops a plan based on the results. The hospice utilizes the collected data from the needs assessment to develop and implement outreach programs and services that are appropriate and responsive to the hospice and end-of-life care needs of the community it serves.

IA 3.3 Any limitations to provision of care are periodically evaluated with the goal of increasing access and providing more inclusive hospice care in the community.

IA 3.4 The hospice provides education and training to all staff and volunteers related to community needs assessment, cultural sensitivity, and the population it serves.

Practice Examples:

- The community assessment includes key metrics, including but not limited to: average and median length of stay; market death/service ratio; hazards affecting the population; diseases or health conditions; analysis of referral source patterns; Centers for Disease Control (CDC) overall causes of death data; and structure and dynamics of human populations, including socioeconomic factors such as employment, housing, education and income, and regional demographic statistics (Resource: [CDC's Community Health Assessment & Health Improvement Planning](#)).

- When conducting the community needs assessment, the hospice considers the presence of diverse cultures, races, ethnicities, and vulnerable/special populations with particular attention to the potential limitations to access for these groups. Vulnerable and specific populations may include individuals with physical and cognitive disabilities, specific diseases/conditions, those residing in long-term care facilities and correctional facilities, and Veterans.
- The hospice records and tracks the periodic evaluation and planned strategies to adapt the hospice's services to meet the community's needs.
- An annual community education seminar is conducted that addresses an important hospice topic identified by the needs assessment (e.g., pain management, advance care planning and advance directives, physician-assisted suicide).
- The hospice convenes a task force/advisory group to develop ways to increase access to hospice care for diverse communities based on the ethnic and racial composition of the service area. The diverse composition of the community is reflected in the membership of the task force.
- Hospice staff and volunteers receive education related to the patient populations they may interact with during care (e.g., infants; children; young parents; lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other (LGBTQIA+) patients and family members; Veterans and their families). [Other diverse populations/groups should be listed as well in terms of race, heritage, age, socioeconomics, etc.]

Standard:

IA 4: Bereavement education and supportive services are offered to all diverse community populations.

IA 4.1 The hospice provider is recognized as a resource for bereavement services and support.

IA 4.2 Bereavement services are accessible to anyone in need of support regardless of race, ethnicity, or language, whether they received hospice services or not.

IA 4.3 Bereavement expertise is available to any community member and organization impacted by loss.

IA 4.4 Education is provided on grief, loss, and other bereavement-related topics for diverse populations in the community.

Practice Examples:

- The hospice informs the community about its bereavement services, programs, and the availability of support groups through regular communication in its own publications and other means, and through community media resources that are applicable to the diverse populations in their service area.
- Community bereavement needs are evaluated, and programs are implemented to meet the diverse community's identified needs.
- Community education activities are marketed to disparate groups in the community. The hospice demonstrates its commitment to the community at large and the partners it serves by holding bereavement support groups for bereaved facility staff.
- The community is invited to participate in bereavement programs.
- The hospice actively promotes the community's understanding of grief and loss by sponsoring community educational programs in partnership with other community organizations (e.g., funeral homes, other healthcare providers, churches).

- The hospice collaborates with community crisis organizations and invites them to include hospice staff and services as part of their work.
- Programs (e.g., training, education, employee assistance programs and support) are developed to assist in meeting the bereavement needs of schools, businesses, law enforcement agencies, other health care entities, and emergency response teams.
- A systematic process is developed and implemented to respond to diverse community inquiries and concerns related to general bereavement issues.



Organizational Excellence (OE)

Organizational Excellence (OE)

Principles

Building a culture of quality, accountability, transparency, innovation, and service excellence within an organization that values collaboration and communication and ensures ethical business practices.

Standard:

OE 1: Hospice operations comply with all applicable federal, state, and local regulations.

Practice Examples:

- Contracts are obtained with providers that meet the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier quality and accreditation standards.
- Medications are regularly reviewed for relatedness to the terminal prognosis and are billed to the appropriate payer.
- Drug disposal policies follow Federal, state, or local requirements.

Standard:

OE 2: The hospice accurately represents its services to the public.

OE 2.1 Hospice marketing materials and hospice representatives accurately describe patient eligibility, benefits, scope, capabilities, and cost of all covered services.

OE 2.2: The hospice follows current regulatory guidance from the Office of the Inspector General (OIG) related to providing gifts of nominal value to referrals sources, community partners, and patients and provides ongoing education to applicable hospice staff on these guidelines.

Practice Examples:

- Speaker's bureau members are trained in the core services provided specifically by the hospice and the provisions of the Medicare and Medicaid hospice benefits or other insurance coverage.
- All marketing materials are reviewed annually to ensure information is up to date and services are clearly defined and explained.
- The hospice provides orientation and training to partnering providers such as hospitals, nursing facilities, or assisted living facilities regarding hospice services.

- Patient information materials clearly explain the scope of the hospice's services, the palliative rather than curative goal of hospice care, waiver of Medicare/Medicaid benefits, hospice costs, and patient cost-sharing.
- The hospice provides a process for offering the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" (Elections Statement Addendum) during the admission process.
- All marketing staff receive education about Federal Anti-Kickback Statute (AKS) and guidance about providing gifts to referrals sources, community partners, and patients.

Standard:

OE 3: Hospice processes are designed to collect and manage information to support the delivery of care and other operations.

OE 3.1 Data are routinely collected related to the allocation and utilization of services in all care settings, including but not limited to:

- Average and median length of service (LOS);
- Days of service by level of care (routine home care, continuous home care, respite care, inpatient care);
- Length of time from referral to admission;
- Services provided and visits made by all disciplines, including hospice aide visits, bereavement contacts, volunteer contacts, and number of volunteer hours;
- Medicare hospice quality reporting program (HQRP) measure data;
- Data required for the annual hospice cost report submitted to the Medicare Administrative Contractor (MAC);
- Data related to compliance with applicable laws and regulations; and
- Data required for reports for aggregate and inpatient cap liability.

OE 3.2 The hospice has a plan for systematically monitoring and evaluating the allocation and utilization of services provided to patients and families in all care settings, which includes but is not limited to:

- Ensuring all patients meet medical eligibility requirements for hospice care;
- Evaluating timeliness of admissions;
- Examining LOS data for potential problems (e.g., short LOS, long LOS, patterns of live discharge) across all settings;
- Evaluating the availability and appropriate utilization of all levels of care (e.g., routine home care, general inpatient care, respite care, and continuous home care) via CMS Hospice Program for Evaluating Payment Patterns Electronic Report (PEPPER) and other federal data sources;
- Ensuring the provision of bereavement services to family members and facility staff;
- Analyzing and evaluating patient and family/caregiver care outcome data;
- Evaluating appropriateness of and reasons for live discharges;
- Examining the rate and reasons for hospitalizations, emergency room visits/observation stays, specialty physicians, and services not related to the terminal diagnosis and related conditions;
- Examining staff productivity; and
- Utilizing comparative statistical information in the evaluation process (e.g., CMS Hospice PEPPER, Medicare Care Compare, NHPCO's Measures of Excellence, CMS Medicare Provider Utilization and Payment Data: Post-Acute Care and Hospice)

OE 3.3 Financial information is routinely reviewed, including but not limited to:

- The annual operating budget to identify variances with planned expenses and income;
- Accounts receivable and accounts payable to ensure that accounts are handled in a timely manner;
- Accounting processes to ensure compliance with general accounting procedures;
- Billing procedures to ensure compliance with regulations;
- Compliance with cap requirements;
- Compliance with cost report submission to MAC;
- Audits of claims forms prior to transmitting billing to MAC; and
- Patient clinical and documentation reviews to ensure the following:
 - Patient eligibility throughout service period;
 - Dates of election of the Medicare and Medicaid hospice benefits;
 - Hospice election statement and addendum requirements;
 - Completion of the face-to-face encounter requirement for compliance with the required timeframes;
 - Physician narrative certification/recertification summary of terminal status; and
 - Level of care documentation requirements are evidenced.

Practice Examples:

- Reports with statistical information on service utilization and hospice operations are generated and analyzed on a monthly or, at a minimum, quarterly schedule.
- The hospice conducts performance improvement projects to improve billing processes and ensures that each project includes an aim statement.
- Managers are accountable for adhering to the budget for their departments and reviewing all related invoices and payments.
- Inaccurate billing is identified, corrected, and resubmitted for payment. Reasons for inaccuracies are identified to monitor for issues present among a number of claims.
- A system is in place to file the Notice of Election (NOE) and Notice of Termination/Revocation (NOTR) in the Fiscal Intermediary Standard System (FISS) within the required time frames, with a focus on timeliness and accuracy.
- A system is in place to determine the benefit period of a patient prior to admission using the HIPAA Eligibility Transaction System (HETS), as well as a process for scheduling face-to-face encounters to comply with the required timeframe for recertification.
- Utilization of services data are collected and compared to state, regional and national level results from the Hospice PEPPER.
- A system is in place that ensures that the physician narrative statement documenting the patient's eligibility and prognosis for hospice services is written by the physician, completed, signed, and dated for each certification of terminal illness.
- A system is in place to ensure the accuracy of documentation of medications and refills listed on the bill.
- A system is in place to ensure accuracy of postmortem visit billing.

Standard:

OE 4: Operational information is collected and disseminated to appropriate individuals in a timely manner.

OE 4.1 Operational information is communicated to all hospice staff, the governing body, and volunteers on a regular basis.

OE 4.2 The hospice utilizes external industry data for comparison and participates, whenever possible, in external data collection initiatives.

OE 4.3 There is evidence that collected and reviewed data and information are the basis for decision making related to hospice operations.

Practice Examples:

- Hospice leaders regularly review patient care costs and other financial data and share relevant information with staff on a regular basis.
- Medications are reviewed to ensure that hospice is paying for medications related to the terminal diagnosis and related conditions.
- The Quality Assurance and Performance Improvement (QAPI) Program includes both clinical and operational performance improvement projects and utilizes reports and graphs with comparative data for benchmarking.
- The hospice participates in state and national comparative operational data collection and reporting initiatives (e.g., NHPCO's Measures of Excellence survey and dashboard, state hospice and palliative care organization survey, electronic medical record (EMR) benchmarking).
- The governing body reviews financial data at each meeting and takes follow-up action as necessary.
- The governing body reviews QAPI program data at regular intervals and takes follow-up action as necessary.



Workforce Excellence (WE)

Workforce Excellence (WE)

Principles

The hospice fosters a collaborative, interdisciplinary environment that promotes diversity, equity, inclusion, individual accountability, and workforce excellence through professional development, training, and support to all staff and volunteers.

Hospice organizational leaders ensure that staffing and qualifications of staff and volunteers are appropriate to the scope of care and services provided by the hospice program.

Standard:

WE 1: The hospice identifies and maintains appropriate staffing of qualified employees, volunteers, and contracted staff to meet the unique needs of the patients, families/caregivers, and the organization to ensure that core services are provided.

WE 1.1 The hospice's administrative leadership ensures that all employees, volunteers, and contracted staff who provide patient and family/caregiver services are competent in their area(s) of practice.

WE 1.2 The hospice has written policies and procedures describing its method(s) for assessing competency of clinical staff and plans for staff development training.

WE 1.3 The hospice ensures applicable staff have current licensure, certifications, or other credentials appropriate to their practice and scope of responsibilities in accordance with applicable laws and regulations in the states where they practice.

WE 1.4 The hospice ensures that physician services are available through contract, direct employment with the hospice provider, or on a volunteer basis.

WE 1.5 The hospice establishes and utilizes appropriate staffing guidelines for staff recruitment, retention, and assignments to ensure continuous quality of patient care.

WE 1.6 The hospice ensures a patient's care or treatment is not negatively affected if the program grants a staff member's request not to participate in an aspect of a patient's care or treatment, such as for ethical, health, or personal reasons. The hospice does not penalize an employee for requesting not to participate in a modality of care or treatment for ethical or spiritual reasons.

WE 1.7 The hospice has identified a plan to respond to significant increases or decreases in census, based on strategic planning and staffing guidelines.

Practice Examples:

- Professional licenses are verified at least annually with the licensing body and documented in personnel records.
- The hospice maintains accurate and current personnel records to support proof of current licensure, certification, or other required credentials.

- An employee whose license is expired or suspended is not allowed to work until the license is reinstated and verified.
- Documentation of hospice aide attendance at required monthly one-hour in-services is filed in each hospice aide employee record to reflect a total of twelve (12) in-service hours in a calendar year.
- Education and organizational membership activities are documented in each staff member's personnel record.
- The hospice ensures a social worker with a Master of Social Work (MSW) degree supervises any social worker with a Bachelor of Social Work (BSW) degree hired after December 2, 2008, as well as staff with background in a related field who are functioning in a social work position.
- Additional staff is secured and/or contracted under non-routine circumstances, such as unanticipated periods of high patient census and case load, staffing shortages due to illness, or other short-term temporary situations that may interrupt patient care.

Standard:

WE 2: The hospice recruits staff and volunteers to reflect the diversity of the population in the community served.

WE 2.1 The hospice conducts an annual analysis to determine how the diversity of staff and volunteers correlates with the community served.

WE 2.2 The hospice recruitment plans and hiring activities demonstrate nondiscriminatory hiring and staffing practices.

Practice Examples:

- Recruitment efforts are aimed at hiring staff and volunteers who reflect the ethnicity, diversity, and other characteristics of the population served.
- Community centers, places of worship, neighborhood associations, and local cable TV stations are examples which may be utilized to recruit diverse staff and volunteers from ethnic groups not well represented on the hospice's staff.

Standard:

WE 3: The hospice maintains a consistent nondiscriminatory process for recruiting and selecting staff with optimal qualifications which includes competence and license validation, a personal interview, criminal background checks, and other substantiation as required by state or federal law and regulation.

WE 3.1 The hospice's administrative leadership defines the qualifications and performance standards for all staff positions in alignment with federal/state regulations.

WE 3.2 The hospice has a written job description that includes education, training and experience requirements, responsibilities, duties, and reporting lines for each position.

WE 3.3 Job descriptions are reviewed and updated on a regular basis or as needed.

WE 3.4 Personnel records are updated at least annually and include but are not limited to the following:

- Verification of licensure;
- Completed employment application;
- Verification of experience;
- Employee health screening records maintained in a separate secure file;
- Pre-employment screenings;
- Annual performance evaluations;
- Confidentiality Agreement;
- Reference checks;
- Criminal background checks for staff and volunteers;
- The Office of the Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) (at hire and monthly);
- Completed Form I-9 or Employment Eligibility Verification (excluding volunteers);
- Conflict of interest form;
- Child/adult abuse clearances per state requirement;
- Competency assessments for clinical staff;
- Documentation of orientation to organization;
- Verification of certifications; and
- Other information as required by law, policy, or regulation.

WE 3.5 Each employee is provided copies of their job description upon hire and per organization's policy/procedure.

Practice Examples:

- Potential employees receive a job description for the position for which they are applying.
- Supervisors evaluate the accuracy of a job description annually with input obtained from each employee in the position and make revisions as necessary.
- The hospice develops a personnel handbook and provides access for each employee at hire and when changes occur.
- The hospice educates employees about federal/state hospice regulations and their role in maintaining compliance.
- Qualifications are defined in writing for all hospice team members and are included in position descriptions.
- Selection of hospice team members is made based on the applicant's experience and education; communication and interpersonal skills; clinical or other specialty skills; experience related to loss, grief, and dealing with complex psychosocial issues; and ability to work effectively within the demands of the hospice role/position and as a team member.
- The hospice utilizes a consistent process for recruiting and selecting staff with optimal qualifications based on interviews with managers, peers, and others.
- The hospice maintains personnel records and credentialing information for the medical director and other physicians employed or contracted with the hospice, including Drug Enforcement Administration (DEA) registration.

Standard:

WE 4: The hospice has established personnel policies to direct employment practices that include:

- Recruitment;
- Hiring practices;
- Benefits;
- Grievance procedures;
- Employee responsibilities;
- Staff conflict of interest;
- Performance expectations and evaluations;
- Disciplinary actions;
- Retention activities and efforts;
- Termination; and
- Reporting of fraud, waste, and abuse

WE 4.1 Upon hire, every staff member is oriented to the hospice's personnel policies and procedures.

WE 4.2 Hospice personnel policies are regularly reviewed and updated.

WE 4.3 The hospice has a method for staff to express grievances (including anonymously) related to their employment and processes for resolving grievances and evaluating the grievance process.

WE 4.4 Hospice personnel policies and procedures meet all regulatory requirements and are in accordance with applicable laws.

WE 4.5 Educational programs are developed in accordance with the hospice's policies and individual competency development needs.

WE 4.6 Educational programs are evaluated by the participants, and the results are used to inform the development of future programs.

Practice Examples:

- The hospice has a written policy directing the regular review of all personnel policies and procedures.
- The hospice utilizes staff with expertise in human resources and the regulatory requirements thereof to develop all hospice personnel policies and procedures.
- An evaluation form is utilized for participant evaluation of all educational offerings. Results are compiled and utilized in determining educational needs and staff development planning activities.
- Staff development and competency needs are evaluated annually, and a plan for education and competency evaluation is developed based upon this assessment.

Standard:

WE 5: All staff receive orientation, training, continuing education, and opportunities for development appropriate to their responsibilities.

WE 5.1 All staff complete appropriate orientation, training, and competency evaluations before providing any care or assuming administrative responsibilities.

WE 5.2 The hospice provides orientation and continuing education programs in hospice care, pain and symptom management, infection control, compliance with regulations, and emergency preparedness to all direct care staff including facility-based and contracted staff.

WE 5.3 The hospice orients newly assigned staff members or volunteers to their responsibilities and to the individualized needs of the patient and family/caregiver and when patient assignments change.

WE 5.4 The hospice has established processes that support staff development and life-long learning.

WE 5.5 Hospice team members have access to emotional support to assist them in coping with work-related loss, grief, and change.

Practice Examples:

- A monthly calendar of available educational opportunities is published and distributed to staff.
- A structured orientation program is in place for all new employees which includes orientation to the hospice and hospice philosophy of care as well as education about death and dying.
- Hospice staff and volunteers are oriented to their job-specific duties.
- Staff members are surveyed annually to assess their learning needs.
- In-service educational offerings include competency evaluations as appropriate.
- The hospice maintains an agreement with a local employee assistance program to provide additional counseling services to staff.
- The hospice provides in-service educational offerings on topics of importance to patient care, including disease-specific information, post-traumatic stress disorder, and other issues faced by Veterans at the end of life.
- The hospice provides technology training for computer systems and electronic medical records.

Standard:

WE 6: The hospice's administrative leadership assures that continuous education is available for all staff in leadership positions.

WE 6.1 The hospice has a systematic process to identify the educational needs of staff in leadership positions on an ongoing basis.

WE 6.2 The hospice has an educational plan to continually enhance the skills and capabilities of staff in leadership positions.

WE 6.3 The hospice regularly provides instruction to staff in leadership positions related to regulatory compliance and quality.

Practice Examples:

- The hospice has qualified staff members who provide education about issues specific to the hospice program.
- The hospice provides educational sessions for members of the governing body as appropriate.

- The hospice provides education related to human resource training (e.g., the Equal Employment Opportunity Commission (EEOC), hiring/firing practices, the Family and Medical Leave Act (FMLA), motivating employees, counseling low performers).
- The hospice facilitates participation in a hospice-specific education program designed to train new leaders in leadership competencies, such as change management, budgeting, conflict resolution, goal setting, and other managerial skills.
- The hospice facilitates participation in a hospice-specific compliance education program designed to train new leaders in rules and regulations, such as the Medicare Conditions of Participation (CoPs), Medicare regulations on eligibility, admission and discharge, other Centers for Medicare and Medicaid Services' (CMS) regulations, False Claims Act, and billing requirements.

Standard:

WE 7: Hospice staff has access to current information relevant to hospice practice.

WE 7.1 Current books, websites, videos, and journals related to current relevant information and evidence-based literature about hospice, palliative care, and bereavement care for all ages are available for the staff use.

WE 7.2 Staff members have access to up-to-date relevant information through attendance at internal and external education programs and seminars.

Practice Examples:

- The hospice makes current research and clinical information readily available by providing internet access for staff.
- Hospice leadership encourages staff to attend internal and external education programs and seminars.

Standard:

WE 8: The hospice develops and implements a competency assessment program for all staff and volunteers responsible for providing direct patient care activities.

WE 8.1 The hospice has a competency assessment program based on the performance of staff and volunteers who provide hands-on patient care to identify their educational needs.

WE 8.2 The hospice assesses individual staff and volunteer ability to meet the performance expectations set in the job description.

WE 8.3 The hospice provides education and in-service programs, along with other activities, to maintain and improve staff and volunteers' knowledge, skills, and abilities.

WE 8.4 Appropriate actions are taken when adverse patient outcomes are directly related to an individual's performance.

Practice Examples:

- Supervisors observe staff providing direct patient care and evaluate their competency at least annually and as needed

- When staff performance results in an adverse outcome, the staff member is required to participate in a retraining program.
- Competency-based training is developed to address problematic performance areas.
- Documentation is maintained for all orientation, education, and competency testing carried out by the hospice.
- Clinical staff competencies are evaluated per accreditation standards, professional practice standards, and organizational policy.
- The hospice provides orientation and competency evaluation related to the Medicare Hospice CoPs and state regulations for all staff.
- The hospice conducts competency evaluations and training.

Standard:

WE 9: The hospice utilizes and values specially trained caring volunteers capable of assisting the population served by the hospice.

WE 9.1 The hospice employs volunteer managers/coordinators to serve the hospice program through oversight of the volunteer program. Hospice volunteer manager/coordinator responsibilities include:

- Recruiting, screening, and retaining volunteers to meet the needs of patients, families, and the hospice program (e.g., administration, fundraising);
- Educating volunteers to meet hospice regulatory requirements and all applicable accreditation standards;
- Identifying and responding to patient and family/caregiver volunteer needs by matching volunteers with skills needed;
- Advocating for the utilization and integration of volunteers into the hospice interdisciplinary team (IDT) and liaise among team members and volunteers as needed to ensure patient and family/caregiver needs are met;
- Providing ongoing supervision and competency evaluation of volunteers in accordance with hospice regulatory requirements and all applicable accreditation standards;
- Ensuring accurate documentation of volunteer visits and volunteer hours by following documentation standards and agency policies;
- Promoting retention of volunteers through recognition, education, and support;
- Developing strategies for evaluation of the volunteer program to ensure high quality volunteer services;
- Supporting the hospice's community education efforts using volunteers for presentations or other activities in the community;
- Calculating and documenting the monetary value of volunteer hours and cost-savings.
- Maintaining enough volunteers to provide administrative or direct patient care in an amount that, at minimum, equals five (5) percent of the total patient care hours of all paid hospice employees and contract staff;
- Validating the augmentation of care and services achieved using volunteers (e.g., addition of volunteer music therapist); and
- Ensuring that volunteer personnel files are up to date.

WE 9.2 Hospice volunteer services are based on initial and ongoing assessments of patient and family/caregiver volunteer needs by members of the hospice IDT. The scope and frequency of volunteer services are included in the IDG plan of care and are reviewed, revised, and documented regularly in accordance with regulatory requirements and patient and family/caregiver needs.

WE 9.3 Hospice volunteers receive appropriate orientation and training prior to providing services to the patient and family/caregiver. The orientation and training include but are not limited to the following:

- The purpose and focus of hospice philosophy and hospice care;
- Regulatory requirements for the use of volunteers in the provision of hospice care;
- The value and contribution of the volunteer and the spectrum of volunteer duties and responsibilities;
- The hospice IDT's function and responsibility;
- Role of various hospice team members;
- Concepts of death and dying;
- Communication skills;
- Confidentiality and protection of patient and family/caregiver rights;
- Care and comfort measures;
- Diseases and conditions experienced by hospice patients;
- Psychosocial and spiritual issues related to death and dying;
- Concept of the patient and family/caregiver as the unit of care;
- Stress management;
- Infection control practices;
- Professional boundaries and patient/family/caregiver boundaries;
- Staff, patient, and family/caregiver safety issues;
- Ethics and hospice care;
- Family dynamics, coping mechanisms, and psychological issues surrounding terminal illness, death, and bereavement;
- Reporting requirements related to changes in patient condition, pain, and other symptoms;
- Other topics based on the hospice's unique mission, patient population served, and any specific state licensure requirements;
- Specialized duties and responsibilities;
- Specialized training for care and services in facility-based care settings or for patient populations with special needs or considerations; and
- Information on whom to contact for assistance and instructions regarding the performance of duties and responsibilities including procedures to be followed in an emergency or the death of the patient.

WE 9.4 The hospice maintains personnel records for each volunteer that, at a minimum, include:

- Job description or description of the type of activities carried out;
- Orientation and training;
- Competency assessments;
- Annual performance evaluations;
- Criminal background checks;
- Conflict of Interest form;
- Record of certifications and licensure, as appropriate;
- Driver's license checks;
- Mandated reporting of child/adult abuse responsibilities per state requirement;
- Corporate compliance education;
- OIG LEIE clearance checks if the volunteer is a participating Medicare provider or entity;
- Employee (all staff included in Medicare hospice definition of employee) health requirements (e.g., Tuberculosis testing, mandatory vaccines); and
- Initial application and signed job description.

WE 9.5 Volunteers are evaluated at least annually using the performance criteria defined in the job description.

WE 9.6 Volunteers receive regular and ongoing supervision in accordance with policies and procedures established by the hospice.

WE 9.7 Volunteers are represented on the IDG either in person or through staff responsible for volunteer supervision.

Practice Examples:

- Recruiting activities are regularly scheduled and include various media such as print and electronic newspapers, newsletters, bulletins, and other broad-based community resources.
- The hospice has written criteria for recruiting, selecting, training, and assigning volunteers.
- Recruiting activities are planned and conducted with input obtained from staff and volunteers to meet volunteer recruitment goals.
- Volunteer retention activities include offering support groups, partnering with other volunteers, or making changes in assignments if necessary.
- Volunteer retention efforts may include support mechanisms; a mentoring or "buddying" program with experienced, competent peer volunteers; changing of assignments when the program's, patient's, or family/caregiver's needs are not met; providing ongoing feedback and informal and formal recognition; opportunities for communicating and camaraderie with other hospice team members (e.g., support groups, telephone calls, flyers, closure of care, meeting with volunteer coordinator).
- All patient care volunteers complete a comprehensive orientation prior to providing any patient, family, or caregiver care or services.
- Volunteers successfully apply information received in orientation in performance of their regular duties.
- Volunteers are invited to be active participants in supportive groups for volunteers.
- The hospice has a record keeping system for tracking ongoing supervision and evaluation of hospice volunteers as well as identification of their educational needs.
- Each volunteer's performance is assessed on hire and ongoing through observations made during orientation, evaluations made during care assignments, and the annual performance evaluation process.
- Performance evaluations incorporate the educational components of the hospice's orientation and ongoing educational initiatives. A review of these evaluations demonstrates a positive correlation between the educational material presented and the volunteer's demonstrated competence.
- There is a formalized process to elicit feedback from volunteers about the recruitment process, orientation and training, supervision, and their experiences with patients and families.
- Supplemental training is provided for hospice volunteers working in facility settings and/or with patients with special needs (e.g., nursing homes, assisted living facilities, pediatric programs, Veterans, death vigils).

Standard:

WE 10: Adequate supervision and professional consultation by qualified personnel are available to staff and volunteers during all hours.

WE 10.1 The hospice provides twenty-four (24) hours per day, seven (7) days per week access to qualified consultation and supervision for team members, including volunteers.

WE 10.2 Supervisors and management staff have specialized training and experience, attend ongoing in-services and educational programs, and complete a competency evaluation.

Practice Examples:

- Consultation and guidance from knowledgeable senior staff or clinical professionals are available as needed to staff working after hours and on weekends.
- Supervision of social workers with a baccalaureate degree (e.g., BSW, BA, BS) by Masters-prepared social workers (e.g., MSW) includes documentation in the personnel files of regularly scheduled meetings and content of meetings, including reviews of documentation in the patient record.
- Consultation and specialty resources are available to staff and volunteers.
- When social workers or chaplains/spiritual counselors are supervised by a registered nurse, clinical consultations may be arranged with a qualified professional of the same discipline.

Standard:

WE 11: The hospice IDT members provide quality, outcomes-oriented, coordinated care as defined by current regulatory, professional, competency, and credentialing standards that relate to the team member's practice specialty and principles of hospice IDT practice.

WE 11.1 The care provided by the hospice IDT reflects the scope of each specialty as defined by law and is provided in accordance with the code of ethics and practice standards for each discipline.

WE 11.2 Care is goal or outcome-directed, with the desired outcomes identified by the patient and family/caregiver on the initiation of hospice care and updated on an ongoing basis. Care is consistent with patient and family/caregiver input in the development of goals of care.

WE 11.3 The hospice demonstrates and documents congruency between team members' assessments and interventions and the patient's and family's plan of care.

WE 11.4 Hospice care is provided and documented in a timely manner and in ways that ensure accountability; reimbursement; support of patient rights; and patient, family, and caregiver confidentiality.

WE 11.5 The hospice IDT members meet on a regular basis, and as needed, in compliance with the Medicare CoPs for collaboration and care coordination.

Practice Examples:

- Care coordination and effective communication among the hospice IDT members are evidenced by documentation contained in the clinical record, which evaluates progress toward the achievement of patient-centered goals or outcomes.

- The hospice IDT interventions are collaborative and coordinated and documented throughout the patient's clinical record.
- Members of the patient's and family/caregiver's hospice IDT communicate the anticipated bereavement needs and survivor risk assessment information to bereavement care staff using a consistent mechanism (e.g., survivor risk assessment tool, case summary for bereavement care).
- A process of communication between the patient/family/team is established (e.g., calendar) to coordinate home visits.

Standard:

WE 12: The hospice medical director reviews, coordinates, and oversees the management of medical care for all patients in the hospice program.

WE 12.1 The hospice employs or contracts with a medical director who is a licensed Doctor of Medicine (MD) or Osteopathy (DO) with experience and knowledge of hospice practice and palliative medicine.

WE 12.2 When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director.

WE 12.3 When the hospice provider has multiple locations under the same Medicare provider number, there is only one hospice medical director serving in that role.

WE 12.4 Responsibilities of the hospice medical director include but are not limited to:

- Overseeing the medical component of the hospice's patient care program and supervising other physicians who may be employed or under contract to the hospice. Reporting relationships and supervision should be shown in the hospice's organizational chart;
- Collaborating with the patient's attending physician regarding the palliation and management of the principal illness and related conditions;
- Assuming attending physician responsibilities if the patient has not named an attending physician or if the attending physician is unavailable;
- Reviewing clinical information for each hospice patient, providing written certification of the patient's eligibility for hospice services upon admission and at recertification, and completing and signing initial certification and recertification of terminal illness;
- Composing a brief narrative, in the physician's own words, related to hospice eligibility and patient prognosis to accompany both the initial certification of terminal illness and each recertification;
- Reviewing the patient's clinical record and documenting evaluation of the patient's ongoing eligibility for hospice services, as well as needed treatment and care, prior to the start of each Medicare benefit period;
- Providing oversight of medications and therapies and ensuring that documentation in the patient record specifies which medications are related and not related to the patient's terminal prognosis;
- Providing a hospice face-to-face encounter, or assuring it is done, prior to recertification for patients who are Medicare beneficiaries and are approaching their third or later benefit period;
- Performing home and inpatient visits for patient assessment and intervention as needed and appropriate;
- Acting as a medical resource for the hospice IDT;
- Assuring physician representation at and participation in hospice IDT meetings;
- Collaborating with the hospice IDT in reviewing and documenting care, services, and medications that are related and not related to the terminal prognosis;
- Participating in the hospice's quality assessment/performance improvement activities;

- Providing coverage and support after normal business hours;
- Assisting in the development and review of clinical protocols;
- Acting as a liaison to physicians in the community;
- Developing and coordinating procedures for the provision of emergency care;
- Participating in continuing education for all hospice staff providing direct care;
- Establishing guidelines and parameters for acceptable medical research;
- Acting as a role model to peers;
- Providing educational and consultative assistance related to hospice care;
- Reporting abuse and neglect in accordance with state laws and regulations as well as the hospice's policy and procedures; and
- Reporting communicable disease in accordance with state laws and regulations.

Practice Examples:

- The hospice medical director/hospice physician attends hospice IDT meetings.
- The hospice medical director actively serves on the organizations' Quality Assurance and Performance Improvement (QAPI) committee.

Standard:

WE 13: The patient's attending physician provides initial and ongoing medical services to the patient.

WE 13.1 The attending physician (if any) provides patient clinical information for assessment of hospice eligibility, admission, and provision of ongoing medical services.

WE 13.2 Physician's orders are obtained, as needed, prior to the provision of care and received within the time frame required by state law and regulation.

WE 13.3 The hospice verifies the licensure of physicians, nurse practitioners (NPs), physician assistants (PAs) (effective January 1, 2019), and other authorized individuals who provide orders or prescriptions for a hospice patient and checks for exclusion in Medicare/Medicaid participation

WE 13.4 The hospice communicates the responsibilities of the patient's attending physician to the physician.

WE 13.5 The attending physician's responsibilities for the hospice patient include but are not limited to:

- Signing the certification of terminal illness for benefit period 1 in addition to the hospice medical director (NOTE: NPs and PAs may not sign the certification of terminal illness);
- Managing the patient's medical care;
- Participating in the initial and ongoing care planning process;
- Providing signed orders in a timely manner;
- Respecting the patient's confidentiality and choices;
- Staying available for medical consult to the hospice staff, the patient, and family members;
- Sharing information as needed to facilitate continuity of care; and
- Providing consultation on specialty patient populations.

WE 13.6 The hospice IDT communicates with the attending physician on an ongoing basis. Communication includes providing clinical updates, responding to questions regarding the patient's care and family/caregiver services, and conveying observations and pertinent information.

Practice examples:

- Contacts and communication with the attending physician are documented in the clinical record.
- The attending physician is made aware of any changes in patient status and resulting changes in the plan of care.

Standard:

WE 14: Hospice nursing services are based on the initial, comprehensive, and ongoing assessments of the patient's needs by a registered nurse and are provided in accordance with the hospice IDT's plan of care.

Services include:

- Completion of initial, comprehensive, and updated assessment of patient and family/caregiver needs and provision of direct or supervised nursing services based on the plan of care;
- Coordination of the patient's plan of care with the IDT;
- Provision of dietary counseling by dietician if beyond the nurse's skill set;
- Medication reconciliation and update; and
- Supervision of hospice aides per federal/state regulations.

WE 14.1 Responsibilities of the hospice nurse include:

- Assessing the patient's and family/caregiver's physical, environmental, safety and developmental needs.
- Assessing the patient's/family's psychosocial, spiritual, and bereavement needs if the patient/family refuse assessment from other team members.
- Developing an individualized plan of care, in conjunction with the hospice IDT, based on assessment, identification of needs, and patient and family/caregiver goals and preferences;
- Providing care to patients and families through utilization of interventions and evaluation of outcomes of care;
- Performing ongoing assessment and revision of the plan of care, with interdisciplinary collaboration, in response to the changing needs of the patient and family/caregiver;
- Performing comprehensive assessment of the patient's symptoms and developing an individualized symptom management plan;
- Anticipating, preventing, and treating undesirable symptoms;
- Providing support, instruction, and education of the patient, family, and other caregivers who participate in the care of the patient;
- Documenting nursing assessments, identified problems, measurable goals of care, progress towards goal achievement, limitations to provision of care, care interventions, and response to care;
- Coordinating and collaborating with the hospice IDT and others involved in the patient's care;
- Developing the hospice aide care plan and supervises the aide at least every 14 days and as needed.
- Recognizing and supporting the patient's and family/caregiver's spiritual and cultural beliefs;
- Providing holistic, patient-centered care across treatment settings to ensure continuity of care and facilitate attainment of goals of care;

- Participating in the hospice program's quality assessment performance improvement program;
- Assessing the ability of patient and family/caregiver to safely administer medications and perform treatments; and
- Reporting abuse and neglect in accordance with state laws and regulations as well as the hospice's policy and procedures.

Practice Examples:

- An appropriate physical assessment is performed and documented for each patient upon admission and on subsequent visits.
- The hospice nurse documents assessments of the patient's symptoms, related interventions, and outcomes for each visit.
- The hospice nurse, at admission and on an ongoing basis, reviews all the patient's prescriptions and over-the-counter drugs, herbal remedies, and other alternative treatments that could affect drug therapy.
- The hospice nurse contacts the attending physician as needed for orders, updates, and changes in the plan of care.
- The hospice nurse consults with the pharmacist regarding medications, interactions, and side effects.
- The hospice nurse educates families about payment responsibilities for medications that are unrelated to the terminal prognosis and/or determined to be not medically necessary.
- The hospice nurse educates families about medication disposal per federal/state regulations.
- The hospice nurse is available to perform, assist with, and/or coordinate post-death care.

Standard:

WE 15: Hospice social work services are based on initial and ongoing assessments of patient and family/caregiver needs by a social worker from a school of social work accredited by the Council on Social Work Education (CSWE) and are provided in accordance with the hospice IDT's plan of care.

WE 15.1 Social work responsibilities include:

- Identifying the psychosocial needs of the patient and family/caregiver;
- Assessing and strengthening the coping skills of the patient and family/caregiver;
- Assessing and enhancing the appropriateness and safety of the environment and connecting the patient and family/caregiver with community resources, as needed;
- Providing interventions for management of emotional symptoms (e.g., fear, grief, depression, anger);
- Identifying needs of family members/caregivers and enhancing the strengths of the family system;
- Assessing and referring family for bereavement services;
- Assisting patient and family with education and development of advance care directives;
- Providing education and assistance patient and family related to insurance coverage and applications for assistance.
- Documenting problems, psychosocial assessment, measurable goals, progress towards goals, care and interventions provided, and patient and family/caregiver response to each intervention;
- Maintaining the dignity of the dying patient;
- Supporting the patient's and family/caregiver's spiritual and cultural beliefs;

- Providing holistic family-centered care across treatment settings;
- Coordinating and collaborating with the hospice interdisciplinary team;
- Reporting abuse and neglect in accordance with state laws and regulations as well as the hospice's policy and procedures;
- Assisting with funeral arrangements based on patient and family/caregiver need and preferences; and
- Coordinating the discharge planning process.

Practice Examples:

- The social worker evaluates the patient's and family's adaptation status, related needs, and opportunities for growth.
- The social worker identifies patients who are Veterans and evaluates the Veteran's individual needs related to military service, using the military history checklist.
- The social worker identifies a spouse or other family members/caregivers at high risk for complicated grief and refers them to appropriate services.
- The social worker identifies the need for and plans a family conference with the patient, family members/caregivers, and other hospice team members as well as other persons involved in the care of the patient.
- The social worker coordinates the discharge process when the patient no longer needs hospice services through family counseling, patient, and family/caregiver education, and other service arrangements as needed.
- The social worker discusses the possibility of live discharge with the patient and family at the time of admission.
- The social worker assists the patient and family related to transitions in level of care (e.g., General Inpatient Care (GIP) to Routine Home Care (RHC)).

Standard:

WE 16: The hospice IDT identifies and involves additional professionals and paraprofessionals with the knowledge, training, and skills to meet the specific needs of patients and families/caregivers as identified in the plan of care.

WE 16.1 The hospice ensures that additional professionals are qualified to provide services and that they or their services are:

- Authorized by the hospice with a properly executed contract, as applicable;
- Provided in a safe and effective manner;
- Delivered in accordance with the patient's plan of care;
- Supervised by the hospice team; and
- Provided with education/orientation to hospice services to ensure maintenance of standards of care.

WE 16.2 Auxiliary professionals may include:

- Speech-language pathologists (SLPs), physical (PT), occupational (OT), respiratory, and other therapists;
- Paraprofessional staff (e.g., hospice aides, homemaker);
- Hospice volunteer services, some of whom may be certified;

- Providers of complementary therapies such as massage, music, or aromatherapy; or
- Other individuals based on the patient's, and family/caregiver's unique needs, as requested by the patient and family/caregiver or as ordered by the physician.

WE 16.3 The hospice exercises management of the services provided by professionals and additional services provided by professionals and paraprofessionals regardless of whether the services are provided directly by hospice employees, volunteers, or contracted providers.

WE 16.4 The pharmacist is actively involved as a member of the hospice IDT and provides the following services:

- Reviews all patient prescriptions and over-the-counter drugs, herbal remedies, and other alternative treatments that could affect drug therapy; and
- Identifies the following:
 - Effectiveness and outcomes of drug therapy;
 - Drug side effects or toxicity;
 - Actual or potential drug interactions;
 - Duplicate drug therapy; and
 - Drug therapy currently associated with laboratory monitoring.

Practice Examples:

- The PT providing treatment to a patient attends the hospice IDT meetings and contributes to the plan of care.
- A massage therapist assigned to a patient utilizes massage to alleviate muscular pain and reduce anxiety.
- The hospice contracts with enough additional professionals/paraprofessionals to meet the needs of the patient population served.
- The pharmacist reviews the medication profile for each patient to ensure that drugs and biologicals meet each patient's individual needs and serves as a clinical resource to physicians and nurses.

Standard:

WE 17: Hospice spiritual care and services are based on an initial and ongoing documented assessment of the patient's and family/caregiver's spiritual needs by qualified members of the hospice IDT (e.g., chaplain, clergy, spiritual counselor, or someone with equivalent education, training, and experience) and provided according to the hospice IDT's plan of care.

WE 17.1 Spiritual care and services include:

- Assessing the spiritual status of the patient, family, and caregiver;
- Documenting the spiritual assessment, goals for spiritual care, services provided, and the patient's and family/caregiver's response to spiritual care;
- Acknowledging and respecting the patient's and family/caregiver's beliefs, culture(s), and values related to life's meaning, including suffering and loss, and desire for services/support;
- Meditation, counseling, prayer, sacred rituals or practices, active listening, and supportive presence;
- Assisting with funerals and memorial services as requested by the family/caregiver;
- Communicating with and supporting the involvement of local clergy and/or spiritual counselors as needed and as desired by the patient, family, and caregiver;

- Consulting with and providing education to hospice IDT members and patients and families/caregivers about spirituality and related care and services; and
- Reporting abuse and neglect in accordance with state laws and regulations as well as the hospice's policy and procedures.

Practice Examples:

- The hospice chaplain/spiritual counselor explains to the team the specific beliefs of a patient, and the team discusses the implications of those beliefs for that patient's care.
- The hospice chaplain/spiritual counselor counsels the patient who is a Veteran on spiritual issues related to military service.
- Other members of the hospice IDT who have identified spiritual needs of the patient/family/caregiver consult with the hospice chaplain/spiritual counselor about how to best address those needs.
- The hospice chaplain/spiritual counselor provides education to community clergy on spiritual care at the end of life.
- The hospice chaplain/spiritual counselor coordinates the patient's and family/caregiver's spiritual care with community resources (local churches and affiliations) per patient/family/caregiver request.

Standard:

WE 18: Hospice volunteer services include the involvement of trained volunteers in the care of the patient, family, and caregiver and in other aspects of the hospice program.

WE 18.1 Hospice volunteer services include:

- Providing emotional and practical support to patients and families/caregivers;
- Providing respite for the patient's caregiver;
- Assisting in bereavement education and support to survivors;
- Assisting with program administration and development
- Assisting with office duties; Serve on the organization's board or committees, and
- Fundraising for the hospice organization

WE 18.2 The total time spent in patient care by hospice employees and contract staff is matched by at least 5 percent in total volunteer direct patient service and/or administrative patient support service hours on an annual basis.

Practice Examples:

- The hospice recruits and trains an adequate number of volunteers to fill requests made by the hospice IDT.
- Volunteers provide end of life vigil support for the patient and family.

Standard:

WE 19: Hospice aide services are based on the registered nurse's initial and ongoing assessments of the patient's personal care needs, patient goals of care, and ability to perform activities of daily living (ADLs).

WE 19.1 The hospice nurse develops and communicates an aide care plan based on patient assessment of the patient's personal care needs and any additional instructions related to the patient's care. This communication includes the:

- Patient's cognitive status, current and changes in functional status related to feeding, personal hygiene, elimination, and mobility;
- Family/caregiver's knowledge, ability, willingness, and confidence to provide care;
- Duties to be performed by the hospice aide; and
- Patient's preferences, wishes, and decisions regarding end-of-life care.

WE 19.2 The hospice nurse communicates in a timely manner to the hospice aide changes to the aide care plan.

WE 19.3 The hospice aide's services and responsibilities include:

- Assisting with personal hygiene, elimination, feeding, and mobility according to the patient's needs and the nursing instructions as identified in the care plan;
- Not providing services outside of the aide care plan;
- Maintaining infection control and safety practices;
- Providing support for and reinforcement of the team's instruction for the patient's caregivers;
- Communicating with the hospice nurse regarding services provided, significant findings regarding the patient's functional status and change in care needs, and refusal of care;
- Documenting the care provided and the patient's response to care;
- Participating with the hospice IDT in the development and implementation of the patient's and family/caregiver's plan of care; and
- Reporting abuse and neglect in accordance with aide scope of practice as well as the hospice's policy and procedures.

Practice Examples:

- The hospice nurse completes and regularly updates the aide care plan that outlines the patient's needs and duties to be performed by the hospice aide.
- The hospice aide attends the hospice IDT meetings and provides input for the care planning process.

Standard:

WE 20: When the patient is receiving hospice aide services, the hospice nurse evaluates and supervises the aide services.

WE 20.1 The hospice nurse documents the supervision of the hospice aide's services in the patient's clinical record. The documentation includes an evaluation of the direct care provided, the patient's and family/caregiver's perception of the care provided, and the aide's adherence to the care plan.

WE 20.2 The hospice RN visits the home at least every fourteen (14) days to assess the quality of care and services provided by the hospice aide for a specific patient's plan of care and to ensure that services identified by the hospice IDT meet that patient's needs. The hospice RN documents the visit and relevant assessments. The hospice aide does not have to be present during this visit unless required by state law/regulation.

WE 20.3 When hospice aide services are not satisfactory, the hospice nurse takes action to address and resolve the issues.

WE 20.4 Annual visits are completed by the RN with the hospice aide competency evaluation as warranted with state regulations or accreditation standards.

Practice Examples:

- The nursing visit note includes documentation of an evaluation of the hospice aide's services during each nursing visit.
- The nurse investigates and addresses the stated concerns when the patient or family/caregiver expresses dissatisfaction with a hospice aide's services.

Standard:

WE 21: The patient's hospice physician provides initial and ongoing medical services to the patient.

WE 21.1 The hospice physician (if any) provides patient clinical information for assessment of hospice eligibility, admission, and provision of ongoing medical services.

WE 21.2 Physician's orders are obtained, as needed, prior to the provision of care and received within the time frame required by state law and regulation.

WE 21.3 The hospice verifies the licensure of physicians, NPs, PAs (effective January 1, 2019), and other authorized individuals who provide orders or prescriptions for a hospice patient and checks for exclusion in Medicare/Medicaid participation

WE 21.4 The hospice physician's responsibilities for the hospice patient include but are not limited to:

- Signing the certification of terminal illness for applicable benefit periods
- Managing the patient's medical care;
- Participating in the initial and ongoing care planning process;
- Providing signed orders in a timely manner;
- Respecting the patient's confidentiality and choices;
- Staying available for medical consult to the hospice staff, the patient, and family members;
- Sharing information as needed to facilitate continuity of care; and
- Providing consultation on specialty patient populations.

WE 21.5 The hospice IDG coordinates with the hospice physician on an ongoing basis.

Practice Examples:

- Contacts and coordination of care with the hospice physician are documented in the clinical record.
- The hospice physician is made aware of any changes in patient status and resulting changes in the plan of care at the time of the change.



Compliance with Laws and Regulations (CLR)

Compliance with Laws and Regulations (CLR)

Principles

Ensuring compliance with applicable laws, regulations, and professional standards of practice and implementing systems and processes that prevent fraud, waste, and abuse.

Standard:

CLR 1: The organization maintains full compliance with legal and regulatory requirements.

Requirements include but are not limited to:

Medicare Hospice Regulations: The Medicare hospice regulations include the Conditions of Participation (CoPs – Subparts C and D), but also include Subpart A – General Provisions and Definitions, Subpart B – Election and Duration of Benefits, Subpart C – Patient Care, Subpart D – Organizational Environment, Subpart F – Covered Services, Subpart G – Payment for Hospice Services, and Subpart H – Coinsurance. The CoPs are the health and safety requirements that all Medicare certified hospices are required to meet. They are the framework for patient care delivery, administrative and organizational processes, and quality improvement that hospices must comply with in order to receive payment for services under Medicare.

Subpart B contains the regulations related to election of the hospice benefit; certifying and recertifying eligibility; and discharge, revocation, and transfer regulations. Subpart F specifies the requirements for coverage, which specifies what must be done for Medicare reimbursement. The Medicare Hospice regulations are located in the [electronic Code of Federal Regulations](#). NHPCO also provides an [easy-to-read copy of the complete Hospice Regulations](#).

Medicare Hospice Interpretive Guidelines: The Interpretive Guidelines provide additional guidance, questions, and probes established by CMS to assist state survey agency and accrediting organization staff who are reviewing hospices for compliance with the Medicare Hospice Conditions of Participation. The guidelines offer explanation and amplification of the intent of the Medicare hospice regulations, including some examples of questions the surveyor may ask, as well as documents the surveyor may request. The hospice Interpretive Guidelines are a component of [Appendix M of the State Operations Manual](#), which provides guidance for the entire hospice survey process.

The hospice emergency preparedness interpretive guidelines appear in [Appendix Z](#).

State Hospice Licensure Regulations: Most states have requirements a hospice must meet in order to be licensed to provide hospice care and maintain hospice provider licensure in their respective state. State laws differ in regard to the licensure and certification process, and hospices must be in compliance to operate. NHPCO provides links to [all state hospice licensure requirements](#) on the NHPCO website.

Health Insurance Portability and Accountability Act (HIPAA): [Addresses the use and disclosure of "protected health information"](#) (PHI including electronic protected health information (e-PHI)). [HIPAA resources](#) can also be found on the NHPCO website.

The Health Information Technology for Economic and Clinical Health (HITECH) Act: [Subtitle D of the HITECH Act](#) addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules..

HIPAA Omnibus Final Rule: Clarifies the definition of a Business Associate (BA) and delineates what constitutes breaches of regulations and consumer rights including protections for decedents. HHS provides [additional information](#).

Clinical Laboratory Improvement Amendments (CLIA): CMS [Conditions of Participation 418.116\(b\)](#) require a hospice that performs laboratory testing, including COVID-19 testing, to have a certificate for the level of testing being performed.

The Federal Occupational Safety & Health Administration (OSHA): Requires employers to provide their employees with working conditions free from known dangers and enforces protective workplace safety and health standards. [OSHA's website](#) provides additional information.

Benefit Policy Manual, Chapter 9 – Hospice Services: The Centers for Medicare and Medicaid Services (CMS) provides details on [CMS policies for the Medicare Hospice Benefit](#).

Processing Hospice Claims: CMS provides details on billing for the hospice benefit in [Medicare Claims Processing Manual Chapter 11](#).

The Centers for Medicare and Medicaid Services (CMS): CMS often issues "sub-regulatory guidance" through the issuance of [Change Requests \(CRs\)](#) to communicate new or changed policies or procedures that they will incorporate into the CMS Online Manual System.

Hospice Quality Reporting Program (HQRP) Regulations: [CMS requires hospice providers](#) to report Hospice Item Set (HIS) and [Hospice Consumer Assessment of Healthcare Providers and Systems \(CAHPS\)](#) data per designated timeframes. Hospices that fail to report data will receive a reduction in their market basket percentage increase for that fiscal year.

The Medicare Hospice Certification Process: CMS provides information on the Medicare certification process in the [State Operations Manual \(SOM\) Chapter 2](#).

Financial Liability Protections: CMS Chapter 30 provides instructions regarding issuance of the Advance Beneficiary Notice (ABN) and the Notice of Medicare Non-coverage (NOMNC) to the Medicare beneficiary in advance of initiating, reducing, or terminating what they believe to be non-covered items or services. [CMS provides Beneficiary Notices Initiative forms](#).

For hospice elections beginning on or after October 1, 2020, in the event that the hospice determines there are conditions, items, services, or drugs that are unrelated to the individual's terminal illness and related conditions, the individual (or representative), non-hospice providers furnishing such items, services, or drugs, or Medicare contractors may request a written list as an addendum to the election statement (the addendum must be titled "Patient Notification of Hospice Non-Covered Items, Services, and Drugs").

Hospice Cost Report: CMS provides forms and completion instructions for the hospice cost report. Hospice costs must be reported by level of care and submitted to the MAC within 5 months after the end of the fiscal year. The cost report forms and instructions are in [Chapter 38](#). The hospice cost report forms and instructions can be found in Chapter 38.

The HHS Office of Inspector General (OIG): OIG is charged with protecting the integrity of Department of Health and Human Services (HHS) programs, including hospice. [OIG work plans and reports](#) provide information on the office's areas of focus related to hospice compliance. The [NHPCO website](#) has a list of important OIG reports on hospice as well as an ongoing list of OIG workplan items that impact hospice.

The HHS Office of Inspector General Publication of the OIG Compliance Program, Guidance for Hospices: Provides [specific guidance for hospice programs](#), including the 7 fundamental principles for an effective compliance program and 27 risk areas identified specifically for hospice programs. Although published in 1999, the information and guidance are still relevant today and are regularly referenced.

Reporting Fraud and Abuse: The HHS OIG has created an OIG Fraud Hotline, which accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. More information about the HHS OIG efforts to combat Medicare fraud and abuse can be found [on the HHS OIG website](#).

CLR 1.1 The governing body adopts bylaws in accordance with the mission of the organization.

CLR 1.2 Mechanisms are in place to address the recommendations made in the reports received from authorized regulatory and accrediting bodies.

CLR 1.3 The hospice has a comprehensive compliance program that includes:

- The development and distribution of written standards of conduct, as well as written policies and procedures, which promote the hospice's commitment to compliance and address specific areas of potential fraud such as Medicare hospice eligibility and admission, improper financial relationships with nursing facilities and other healthcare professionals and entities, and improper billing practices;
- The designation of a Compliance Officer and other appropriate bodies (e.g., a Corporate Compliance Committee) charged with the responsibility of operating and monitoring the compliance program and who report directly to the CEO and the governing body;
- The development and implementation of regular, effective compliance education and training programs for all relevant employees;
- The creation and maintenance of a process such as a confidential hotline or other reporting system to receive complaints and ensure effective lines of communication between the Compliance Officer and all employees, as well as the adoption of procedures to protect the anonymity of complainants and shield whistleblowers from retaliation;
- The use of audits and/or other evaluation techniques to monitor compliance and identify problem areas for improvement;
- The development of appropriate disciplinary mechanisms to enforce standards and the development of policies to address:
 - Employees who have violated internal compliance policies, applicable statutes, regulations, or federal healthcare program requirements; and
 - The employment of sanctioned, excluded, and other specified individuals. (e.g., OIG or state-level LEIE exclusion lists).
- The development of policies that direct prompt and proper responses to detected offenses including the initiation of appropriate corrective action and preventive measures.

Practice Examples:

- The hospice has a process in place to incorporate regulatory changes into the policies and procedures of the hospice, with specific attention to implementation dates as published in final regulations and offers timely training for employees to ensure compliance.

- Results of surveys are documented in governing body meeting minutes.
- Ongoing mock surveys or self-assessments are conducted regularly to identify areas for improvement and changes are made based on the findings.
- The hospice has a procedure for reporting and investigating compliance concerns.

Standard:

CLR 2: The hospice has a program to identify, prevent, and correct practices that are fraudulent or abusive.

CLR 2.1 Medicare-certified hospices provide care, treatment, and services as specified in Medicare hospice regulations.

CLR 2.2 The hospice uses specific guidelines to determine eligibility for hospice at admission and throughout the hospice service period.

CLR 2.3 The hospice regularly monitors its compliance with regulatory requirements and business practices.

CLR 2.4 Hospice organizations follow state licensure regulations and reporting requirements, including those for fraud and abuse.

CLR 2.5 The hospice monitors, monthly, the HHS Office of Inspector General's List of Excluded Individuals/Entities (LEIE) which provides information about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other Federal health care programs. If available, the hospice also regularly monitors the state specific LEIE for possible exclusions.

Practice Examples:

- The hospice uses resources available for regulatory questions and interpretive guidance. Resources include but are not limited to those from: CMS, NHPCO, Medicare Administrative Contractors (MACs), state hospice organizations, and accrediting bodies.
- The hospice seeks voluntary accreditation from an accrediting body with hospice deeming authority status from CMS.
- There is a process for review of patient eligibility for hospice services prior to admission as well as at the time of recertification. The recertification process may include a hospice physician or nurse practitioner conducting a hospice face-to-face encounter.
- The hospice utilizes CMS regulations, Medicare Administrative Contractors' (MAC) Local Coverage Determinations (LCDs), and clinical assessments in keeping with professional standards of practice for admission to hospice services and recertification for continued provision of services.
- The hospice regularly audits compliance with regulatory requirements and business practices.
- The hospice monitors OIG risk areas and develops a compliance plan based on those risk areas.

Standard:

CLR 3: The hospice maintains a comprehensive, timely, and accurate clinical record of services provided in all care settings for each patient and family/caregiver.

CLR 3.1 The hospice has written policies and procedures that address the content, maintenance, security, storage, retention, and access to hospice clinical records. These policies and procedures conform to all state and federal laws.

CLR 3.2 A professional, consistent format is used to document the services provided in all care settings.

CLR 3.3 Documentation in the hospice clinical record is descriptive, timely, accurate, and at a minimum includes:

- A clinical history including evidence of the terminal prognosis on admission;
- An age-appropriate physical assessment of the patient by the hospice nurse;
- A comprehensive medication reconciliation;
- Evidence that hospice provider's-controlled drug disposal policy was provided to and reviewed with patient and family;
- A psychosocial assessment of the patient, family, and caregiver;
- A spiritual assessment of the patient, family, and caregiver;
- A bereavement assessment of the patient, family, and caregiver;
- Physician certification and recertification of terminal illness form(s);
- Physician certification and recertification of terminal illness which includes a narrative statement(s) and accompanying attestation statement;
- Clinical documentation of face-to-face encounters and attestation statement on the recertification of terminal illness for the third and subsequent benefit periods;
- CMS quality measure data elements;
- The hospice interdisciplinary team plan of care;
- A record of the care provided by all disciplines from admission through patient death;
- Patient responses to medications, symptom management, treatments, and services;
- Signed physician's orders for care;
- Persons to contact in an emergency;
- Hospice election statement and "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" (election statement addendum) if requested;
- Election statement addendum documentation includes date requested, date hospice provided addendum and by what means (in person, by mail) and if addendum was not signed, documentation about reasons;
- Informed consent and acknowledgment signed by patient or representative that a copy of the notice of rights and responsibilities, privacy practices, and information about advance directive were provided;
- The patient's decisions regarding end-of-life care;
- Advance care planning choices;
- A record of military service for all patients;
- Identification of other agencies involved in care;
- Communication regarding care or services to be provided and care coordination;
- Additional information as required by law and regulation;
- Evidence that the patient or representative received written patient rights and information about how to voice a complaint; and
- A record that drug disposal was carried out in accordance with federal, state, and local regulations.
- CLR 3.4 When services are provided under a contractual agreement, clinical documentation or a summary of services provided by the contracted organization or individual is included in the hospice clinical record.

CLR 3.5 Clinical records of patients who transition between levels of care, or transfer to or from the hospice, contain detailed information to promote continuity of care and support care coordination across treatment settings.

CLR 3.6 Forms utilized in the clinical record are reviewed according to established policy and revised as appropriate.

CLR 3.7 The clinical record contains a physician order and discharge summary for every patient discharged alive.

CLR 3.8 The clinical record is completed within the time frame specified by the hospice for every discharged patient and per federal or state regulations if any.

CLR 3.9 The following documents are provided to the nursing facility for each resident for whom the hospice is providing services:

- An up-to-date hospice plan of care;
- Hospice election form and any advance directives;
- Physician certification and recertification of the terminal illness;
- Names and contact information for hospice personnel involved in the patient's care;
- Instructions on how to access the hospice's 24-hour on-call system;
- Hospice medication information; and
- Hospice physician and attending physician (if any) orders.

CLR 3.10 The hospice clinical record provides a description of patient's health status including assessment outcomes, observations, measurements, history, and prognosis, and serves as the legal document describing the health care services provided to the patient.

- The clinical record provides evidence of the quality of patient care by:
 - Describing the services provided to the patient, family, and caregiver;
 - Documenting the patient, family, and caregiver response to care and changes made to the plan of care; and
 - Serving as a primary means of communication between various care providers who are in the patient's home at different times while furnishing different services.
- The clinical record must be correct and complete and should provide sufficient detail to fully describe the level of understanding, involvement, and agreement with the plan of care.

Practice Examples:

- Clinical records of patients discharged alive are reviewed to verify documentation and affirm a discharge physician order and summary was completed in a timely manner.
- All documentation for patients discharged alive is submitted in a timely manner in accordance with the hospice's policies and filed in the clinical record.
- The military history checklist is used to identify a patient who is a Veteran and is used to evaluate the impact of the military experience, develop a care plan specific to the unique issues faced by the Veteran, and determine benefits to which the Veteran and surviving dependents may be entitled.
- Patients and caregivers are given a Notice of Privacy Practices informing them that protected health information is collected and maintained and may be shared with other providers as a part of the treatment plan.

- When changing to a different level of care, the patient's clinical record documents the reason for the change, with clinical findings and an update to the interdisciplinary plan of care. Documentation and the updated care plan are shared, as appropriate, with staff in the facility providing the new level of care.
- When transferring to another hospice, the transferring hospice provides a transfer summary of all care provided, as well as a copy of the interdisciplinary plan of care, copies of signed consents for care, copies of certifications of terminal illness, copies of any hospice face-to-face encounters, and other information as requested by the receiving hospice.
- The hospice routinely evaluates the application of advancing technology including evaluating risks in the use of the technology and addressing potential HIPAA privacy and security regulation violations.



Stewardship and
Accountability (CA)

Stewardship and Accountability (CA)

Principles

The hospice develops a qualified and diverse governance structure and senior leadership that share the responsibilities of fiscal and managerial oversight.

Standard:

SA 1: The hospice has an organized governing body with complete and ultimate responsibility for the organization.

SA 1.1 The governing body meets regularly and is informed of ongoing and current issues affecting the hospice. The governing body receives reports of care, treatment, services, and quality improvement program activities and projects as required by the Medicare Conditions of Participation (CoPs), state licensure regulations, and/or accreditation standards.

SA 1.2 The governing body participates in an annual review of the hospice's policies and procedures and approves final modifications.

SA 1.3 Bylaws and/or policies and procedures specify the roles and responsibilities of the governing body members, staff, and, when appropriate, define the hospice's relationship to any parent organization governing body.

SA 1.4 The governing body develops and implements a written conflict of interest (COI) policy that includes guidelines for the resolution of any existing or apparent COI(s).

SA 1.5 The governing body members participate in an initial orientation and ongoing educational programs designed to enable them to fulfill their hospice responsibilities.

SA 1.6 All governing body members evaluate their initial orientation and continuing education programs.

SA 1.7 The hospice recruits governing body members who reflect a variety of expertise and the cultural diversity of the population, and the communities served.

Practice Examples:

- Governing body meetings are documented and reflect the group's ultimate responsibility for the organization.
- Signed COI and confidentiality statements are obtained at the beginning of governing body service and annually thereafter.
- The content of the governing body orientation and educational sessions are kept on file with dates of presentations and participants.
- The hospice maintains an organizational chart that clearly depicts the relationships between the governing body, management, and staff.

- Governing body members' names are included in minutes and rosters of staff, leadership, and committee meetings they attend.
- The hospice prioritizes diversity and inclusion in its board composition, with the board reflecting the diversity of the population and community served.

Standard:

SA 2: Hospice organization leaders have processes to review and approve the hospice's mission, purpose, vision, and policies which include active participation and input by all stakeholders.

SA 2.1 The hospice develops and regularly reviews its mission and vision statements. At a minimum, this review is undertaken at least every three years but more often as necessary and appropriate.

SA 2.2 The hospice has clear, written administrative and clinical policies and procedures that guide daily hospice operations.

SA 2.3 Policies and procedures are reviewed annually and revised as necessary. Revisions may be made prior to annual reviews in response to changes in regulations or practice.

Practice Examples:

- The management and staff can verbalize the mission and vision statements of the hospice and it is easily referenced in the office setting.
- The hospice has a process for annual approval by the governing body. Additional review and revision may be done as needed.
- The hospice involves members of the hospice interdisciplinary team in policy and procedure development, review, and editing.

Standard:

SA 3: The hospice administrator has full responsibility for the day-to-day operations of the hospice program.

SA 3.1 The governing body oversees the process of selection and evaluation of the hospice administrator and provides ongoing support.

SA 3.2 The governing body has a mechanism for evaluating the performance of the hospice administrator at least annually.

SA 3.3 The performance evaluation of the hospice administrator is documented and reviewed with that individual.

SA 3.4 The hospice administrator implements financial policies and practices that ensure the accuracy and reliability of the financial data.

SA 3.5 The hospice administrator is qualified by education and experience to operate the hospice in accordance with federal, state, and local laws and regulations, and hospice standards of practice.

SA 3.6 The hospice administrator is responsible to the governing body for:

- Implementing, monitoring, and reporting on the hospice's services;
- Ensuring the provision of quality patient care;
- Ensuring that the organization operates in a legal and ethical manner and in compliance with all local, state, and federal regulations;
- Ensuring that performance improvement and safety activities are planned and implemented; and
- Providing the governing body with up-to-date information on a regular ongoing basis.

SA 3.7 In the absence of the hospice administrator, a qualified individual is appointed to carry out day-to-day operational responsibilities.

SA 3.8 The hospice administrator promotes and directs a culture of quality and compliance in all aspects of operational conduct.

Practice Examples:

- The hospice administrator's position description is documented in writing and includes qualifications and role responsibilities.
- The hospice administrator develops and communicates specific organizational goals aligned with the hospice's mission, strategic plan, as well as professional development goals.
- The hospice administrator, administrative leaders, and staff sign confidentiality and COI statements upon employment and annually thereafter.
- The hospice leaders and staff know how to contact the hospice administrator or their designee at all times.
- The governing body conducts an annual written performance evaluation of the hospice administrator including a review of goal achievement.
- The governing body utilizes a performance appraisal tool in evaluating the performance of the hospice administrator.
- The hospice administrator performs a self-evaluation as part of their annual performance evaluation.
- The hospice administrator's performance appraisal process allows for a comprehensive review with input obtained from peers, subordinates, and leaders.

Standard:

SA 4: Administrative leadership ensures effective strategic planning and resource management.

SA 4.1 Administrative leadership establishes a process for the ongoing monitoring of the organization's risks, threats, and opportunities.

SA 4.2 Administrative leadership monitors the adequacy and availability of its economic and human resources to ensure the organization's ongoing viability.

SA 4.3 Administrative leadership establishes a process for determining and responding to the needs of internal and external customers and the community at large.

SA 4.4 The hospice planning process addresses the:

- Basic philosophy of patient-centered hospice care;
- Mission and vision of the hospice;
- Physical, psychosocial, spiritual, emotional, and bereavement needs of patients and families/caregivers; and
- Outreach to ensure access to hospice services by all members of the community.

SA 4.5 The hospice planning process includes:

- Establishment and periodic review of the mission, vision, and short-term and long-range goals;
- Monitoring of goal achievement to ensure that the mission is realized in practice and sustained over time;
- Input from employees, contracted staff, and volunteers; and
- Feedback from patients and families/caregivers served, contract facilities, vendors, and the community at large.

SA 4.6 Administrative leadership communicates the strategic plan to the hospice's staff and governing body, and periodically evaluates the status and results of the plan's execution based on the goals of the stated plan.

Practice Examples:

- A committee structure exists that permits internal and external customers to participate in the hospice's evaluation and planning.
- The hospice reviews and analyzes results of patient and family/caregiver satisfaction surveys, concern and service failure reports, employee engagement surveys, and community focus group input to assess the level of goal and mission achievement.
- Statements of the hospice's mission and vision are clear on its website and other collateral materials.
- The hospice's administrative leadership and staff can verbalize the mission and vision statement of the hospice.
- Administrative leadership regularly communicates strategic plans, goals, and outcomes to staff.
- Staff and/or team goals are aligned with the mission and strategic plan as well as individual professional development goals.
- Staff progress toward goals is reviewed periodically and is included in staff annual performance evaluation.

Standard:

SA 5: Administrative leadership practices fiscal and fiduciary responsibility in management of the hospice's finances.

SA 5.1 Administrative leadership and representatives from all professional disciplines collaboratively develop, implement, and monitor an annual operating budget and long-term capital expenditure plan in compliance with laws and regulations.

SA 5.2 The budget is approved by the governing body and reflects the goals and operations of the hospice program.

SA 5.3 The hospice contracts with an independent certified public accounting firm to conduct a financial audit at least annually.

SA 5.4 Administrative leadership and the governing body regularly monitor and review financial statements, budget documents, and tax documents, as applicable.

SA 5.5 Administrative leadership implements the financial policies and practices that ensure the accuracy and reliability of the financial data.

SA 5.6 Mechanisms are in place to manage accounts payable, accounts receivable, handling of cash, and arrange credit and assistance if needed.

SA 5.7 Policies and procedures that guide ethical, timely, and accurate billing and payment practices are implemented and evaluated on an ongoing basis.

SA 5.8 The hospice prepares a volunteer cost savings report that demonstrates at least 5% of total patient care hours of all paid and contract direct care staff are provided by volunteers.

Practice Examples:

- Administrative leadership receives regular financial reports, can demonstrate knowledge of financial principles and tax reporting requirements, and can explain management and monitoring of the budget.
- Financial policies and procedures exist and include the requirement that investments are reviewed and approved by the governing body.
- An annual financial audit occurs and includes a management report.
- The hospice has a written compliance plan that addresses hospice risk areas identified by the Office of the Inspector General's (OIG) Compliance Program, Guidance for Hospices (published in October 1999 and still valid today) and other areas of concern identified by the Centers for Medicare and Medicaid Services (CMS).
- The hospice has a written policy describing the process to determine whether patients meet criteria for financial assistance established by the hospice.
- The Director of Volunteer Services uses the dollar value defined by The Independent Sector or the Bureau of Labor Statistics each year to calculate the value of the volunteer services in the cost savings report.

Standard:

SA 6: Administrative leadership continually evaluates and assesses organizational performance.

SA 6.1 Administrative leadership continually evaluates and assesses job performance related to fulfillment of the hospice's mission and all other aspects of the organization's operations.

SA 6.2 Administrative leadership assesses educational needs and regularly identifies and participates in educational opportunities based on the assessed needs.

Practice Examples:

- Administrative leadership establishes annual goals related to the accomplishment of the mission and the strategic plan.
- Administrative leadership conducts quarterly and annual reviews of goal achievement and educational activities and implements improvement and/or corrective actions to address any failure to achieve goals.

- The hospice develops and implements a leadership training program.
- Administrative leadership facilitates, with staff involvement, a comprehensive evaluation of the organization, including progress toward fulfillment of the strategic plan annually or more often. A summary of the evaluation is provided to the governing body and staff. Administrative leadership uses the results to inform the process of goal development, quality improvement, and action plans.

Standard:

SA 7: Administrative policies define the roles and responsibilities of the governing body, administration, and the hospice interdisciplinary team.

SA 7.1 The hospice has written administrative and clinical policies and procedures that guide daily hospice operations.

SA 7.2 The hospice maintains written policies and procedures that state the roles and responsibilities of the governing body, administrative staff, hospice interdisciplinary team members, and volunteers.

SA 7.3 Administrative policy and procedures are updated annually and more often as needed.

Practice Examples:

- The hospice's policies and procedures address areas including but not limited to: the compliance program; development, marketing, and fundraising; financial management; human resources management (hiring, termination, benefits, safety, etc.); the quality program; health information management; patient care and safety; and volunteer services.
- The hospice has a written description of responsibilities for members of the governing body.
- The hospice has a written policy that details the annual program review procedure including review of the participation by the hospice interdisciplinary team in policy and procedure development, as well as the review of the policies and procedures.
- The hospice maintains written policies that define the composition, organization, and performance standards of the hospice interdisciplinary team.

Standard:

SA 8: Information is protected against loss, theft, destruction, and unauthorized use and disclosure.

SA 8.1 At a minimum, sensitive and confidential data including financial and patient records are stored in a manner that protects against both unauthorized physical and remote access and damage from fire, water, and electrical malfunction.

SA 8.2 The hospice has a plan for protecting its electronic information that includes:

- Safeguards to prevent unauthorized access to electronic records;
- Safeguards to prevent unauthorized release of protected health information (PHI);

- Safeguards to prevent unauthorized access to computer equipment, servers, storage area networks, mobile devices, network-attached storage devices and backup systems;
- Safeguards to prevent unauthorized access to software applications;
- Strategies for performing and testing routine back-up and storage of electronic records, including secure offsite storage;
- Methods to replace information and the systems required to operate, if necessary;
- Annual completion of the of the Health Insurance Portability and Accountability Act (HIPAA) risk assessment (Department of Health and Human Services' (HHS) HIPAA Security Risk Assessment (SRA) Tool);
- A comprehensive information security policy; and
- A system for authentication of electronic device users and electronic and handwritten signatures.

SA 8.3 The hospice has a written policy for the retention of records (per federal and state guidelines; whichever is more stringent).

Practice Examples:

- The hospice retains clinical records according to state law and for the federally required period of six years.
- If the patient is a minor, the hospice follows state or federal law regarding retention of records that may be different than the record retention for adults.
- The hospice conducts daily back-ups of electronic data to secure storage.

Standard:

SA 9: Confidentiality of information is maintained.

SA 9.1 PHI may only be released for the provision of patient care, billing, or operations, or as directed by federal and state laws and regulations.

SA 9.2 Hospice policy stipulates patient information may only be released with the written consent of the patient or authorized patient representative unless authorized by appropriate legislative or judicial authority.

SA 9.3 The hospice has policies and procedures that address the secure transfer and transmission of confidential patient and family/caregiver information via the use of fax machines, computers, telephones, mobile devices, and other technological mechanisms and routes.

SA 9.4 All hospice employees, contractors, and volunteers are trained on PHI privacy and security and comply with HIPAA Privacy and Security, Health Information Technology for Economic and Clinical Health (HITECH), and Omnibus regulations.

SA 9.5 The hospice has a plan for reporting a breach of unsecured PHI according to state and federal regulations.

Practice Examples:

- All staff members, contractors, students, volunteers, and board members sign a confidentiality agreement upon hire or at the beginning of board service prior to any exposure to patient or family information.
- Corrective action including appropriate coaching, training, and discipline, is in place and documented when confidentiality is compromised or placed at risk of compromise.

- Patients or legal representatives sign a HIPAA Notice of Privacy at admission and additional releases as needed prior to the release of information or sharing of any information.
- The hospice policies and procedures address staff access and use of the hospice's computers (e.g., password, logging off, and authentication process).
- The physical layout of the hospice office and other hospice facilities is conducive to maintaining patient privacy and is regularly assessed to assure patient privacy is maintained.
- The hospice educates staff regarding correct handling of protected information on electronic devices and printed materials, as well as during spoken conversations that include patient information.



Performance Measurement (PM)

Performance Measurement (PM)

Principles

The hospice collects, analyzes, and actively uses performance measurement data to foster quality assessment and performance improvement in all areas of the hospice organization's processes of care, palliative and hospice services, and operations (including those furnished under contract or arrangement).

The hospice defines a systematic planned approach to improving performance including indicators at both the patient and organizational level for which there is evidence that improvement in those indicators will improve palliative care outcomes and end-of-life support. This approach is authorized and supported by the governing body and leadership.

Standard:

PM 1: The hospice's leadership ensures an organization-wide, integrated, data-driven, and outcome-oriented Quality Assurance and Performance Improvement (QAPI) program is implemented.

PM 1.1 The governing body is responsible for ensuring:

- The presence of an ongoing data driven QAPI program that is inclusive of all hospice operations, as evidenced in a written QAPI plan;
- A focus on improved outcomes across all areas of the organization;
- The appointment of one or more individuals to lead the QAPI program;
- The QAPI activities address operational functions of the hospice and reflect the complexity of the organization as well as quality of care and service, including patient safety; and
- An annual review of improvement efforts including evaluation for sustained effectiveness.

PM 1.2 The hospice's administrative leadership is responsible for allocating resources to improve the hospice's processes and systems, including resources for staff and management as well as information systems to facilitate data collection and reporting.

PM 1.3 The governing body, administrative leadership, employees, and volunteers are informed of quality assessment results and performance improvement activities.

Practice Examples:

- Details on performance improvement projects (PIPs) are regularly reported to the governing body.
- An annual comprehensive QAPI program plan is submitted to and approved by the governing body, including quality indicators to be measured and tracked.
- An annual review of the QAPI program, including a summary of the quality indicator outcomes and improvement activities, is approved by the governing body.

- Resources for and leadership of the QAPI program are outlined in the QAPI program plan.
- PIPs are conducted organization-wide and reflect the organization's complexity and scope of services.
- The hospice maintains documentation of the governing body's oversight of the QAPI program and of the reports provided to them.

Standard:

PM 2: The QAPI program is informed by the hospice's strategic plan and supports its mission, vision, and values.

PM 2.1 The hospice's administrative leadership ensures that QAPI program activities are focused on:

- High risk, high volume, and problem-prone areas with consideration of incidence, prevalence, and severity of problems in those areas; and
- The impact on palliative outcomes, patient safety, the patient's and family/caregiver's experience of care, and other quality of care concerns including but not limited to patient-centered care and changes in setting of care.

PM 2.2 QAPI activities, processes, and outcomes enable the hospice to assess all aspects of care, services, and operations, including contracted services.

PM 2.3 The hospice's performance related to the needs, expectations, and experiences of key consumers and stakeholders (e.g., patients, family members/caregivers, physicians, referral sources, contracted vendors, community partners) is evaluated as part of the QAPI program.

Practice Examples:

- The hospice has a written project improvement project (PIP) that describes the areas targeted for data collection, analysis, and improvement and reviews the plan on a regular schedule.
- The hospice has a mechanism, such as a satisfaction survey, to periodically to obtain feedback from key stakeholders as defined by the hospice (e.g., physicians, nursing home staff, hospital administrators).
- The annual budgeting process includes financial funding resources to carry out the performance improvement program.
- The hospice staff and management team facilitate the identification of high priority targets for performance improvement.

Standard:

PM 3: The hospice collects, analyzes, and utilizes multiple types of performance and outcome data, including patient, financial, volunteer, human resources, key operations, and care delivery services data.

PM 3.1 The hospice's administrative leadership and QAPI staff identify the frequency and scope of the data collection activities.

PM 3.2 The hospice's administrative leadership understands performance improvement principles and methods and employs them, utilizing data, to facilitate management decisions.

PM 3.3 Data are collected related to patient and family/caregiver needs, expectations, and outcomes.

PM 3.4 Data sources utilized by the hospice for QAPI may include, but are not limited to:

- Utilization, staffing, and allocation of services;
- Formal evaluation of care and service surveys from families/caregivers (hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS)), pre- and post-death bereavement services, contracted entities, referral sources, physician, volunteers, and community partners;
- Informal evaluation of care and service surveys from patients, families, and other stakeholders as needed.
- Staff satisfaction surveys;
- Clinical records;
- Complaints and reports of service failures from patients, families, referral sources, physicians, contracted vendors, care partners, among others;
- State or federal compliance surveys and/or accreditation surveys;
- Incident, adverse event, and sentinel event reports;
- Infection surveillance;
- COVID-19 vaccination tracking;
- Medical and service review by the Medicare Administrative Contractor (MAC), Recovery Audit Contractor (RAC), Unified Program Integrity Contractor (UPIC), or other government entities or contractors;
- Financial reports;
- Internal and external data sources, such as administrative and operational records, NHPCO's Measures of Excellence (MOE), Survey of Team Attitudes and Relationships (STAR), and Evaluation of Grief Support Services (EGGS) survey, and contracted data surveys as determined by the organization; and
- CMS Hospice Quality Reporting Program (HQRP) measures:
 - Hospice Item Set (HIS)
 - Claims-based measures
 - CAHPS

PM 3.5 A process is in place to review collected data to determine if patterns or trends exist that negatively impact care and/or place the patient or staff at risk. When these trends and their root causes are identified, corrective actions are taken to improve performance and sustain improvements.

Practice Examples:

- The hospice creates and posts a quarterly QAPI dashboard containing key quality indicators.
- Quality indicator data related to the results of each performance improvement activity are presented to staff on a regular basis via the organization's internal communication process (e.g., newsletter, bulletin board or intranet).
- The hospice utilizes an annual self-evaluation tool to identify processes and systems that need improvement.
- Patient-level data are collected to reflect processes of care (e.g., ongoing assessment, plan of care updates) and patient outcomes.
- The hospice regularly reviews results from the CMS Hospice Quality Reporting Program (HQRP) measures and creates performance improvement projects to improve measure scores based on comparison to national level results.
- Financial reports are reviewed and used by administrative leadership to evaluate progress toward goals on a routine basis.
- State and federal government contractor reviews are recorded, addressed in a timely manner, and integrated in the QAPI program.

- The hospice collects data on Veteran's services and evaluates the components and outcomes of the care provided specific to Veteran needs.
- Employee and volunteer satisfaction or engagement surveys are part of the evaluation process for internal improvement.
- Bereavement evaluation of services surveys are sent to caregivers who have participated in bereavement care.
- Data pertinent to inpatient processes are collected and monitored (e.g., responsiveness to patient call lights) for the hospice's inpatient facility.

Standard:

PM 4: The planning, development, implementation, and evaluation of performance improvement activities are comprehensive and collaborative.

PM 4.1 Performance improvement activities are based on objective data and involve collaboration among departments, disciplines, and programs, as well as input from individuals involved in the process targeted for improvement.

PM 4.2 Performance improvement activity results are communicated to employees, volunteers, and administrative leadership and the governing body.

PM 4.3 A process is in place to conduct a root cause analysis when an undesirable outcome or adverse patient event occurs, as well as a mechanism for reporting specific serious adverse events to regulatory agencies as required. The hospice has a policy defining what constitutes an adverse patient event and a serious adverse patient event. Adverse events/serious adverse events may include but are not limited to:

- Patient falls with injury;
- Patient injuries unrelated to a fall;
- Medication errors;
- Adverse drug reactions;
- Durable Medical Equipment (DME) or medical equipment problems;
- Smoking with oxygen resulting in fire incident;
- Unsafe handling or misuse of controlled drugs;
- Uncontrolled symptoms;
- Threatened or actual suicide attempts;
- Patient abuse, neglect, or exploitation;
- Patient death not related to the principal diagnosis or related conditions;
- Patient harm or death related to the use of restraints and/or seclusion; and
- Other problematic events and serious service failures as defined by the hospice.

PM 4.4 Following a serious adverse event, a systematic root cause analysis of the event is conducted to generate preventive and corrective actions and mechanisms.

Practice Examples:

- The hospice has a quality committee or council, with representation from all disciplines and departments, to oversee performance improvement activities.
- The hospice has a policy and procedure for reporting adverse events.

- The hospice regularly and systematically reviews incident reports to identify areas for improvement.
- The hospice provides education and training regarding the QAPI program and activities to employees and volunteers during orientation, when assigned to a performance improvement project team, and throughout their employment/association with the hospice.
- The hospice routinely communicates the activities and results of QAPI process improvement teams.
- The hospice maintains documentation that demonstrates that a root cause analysis is conducted when trends appear in adverse patient events. There is also evidence that the analysis leads to staff training and process improvements to minimize reoccurrences.

Standard:

PM 5: Components of the hospice's QAPI program include a well-defined methodology for improving performance that demonstrates and documents the results of changes in processes and the development of a plan to ensure sustainability of improvements.

PM 5.1 An identifiable and specified methodology is utilized for measurement, goal setting, implementation, evaluation, learning, and change management related to performance improvement activities.

PM 5.2 The hospice adopts an approach to improving performance that includes:

- A systematic process for ongoing assessment of quality of care and services provided;
- An established process for identifying and prioritizing performance improvement activities;
- A defined process for problem solving and performance improvement work;
- A defined process for conducting and documenting performance improvement projects;
- A means to ensure ongoing, systematic, collaborative performance improvement activities;
- Mechanisms for communicating performance improvement activities and results throughout the organization;
- Methods for ongoing data collection and measurement to detect significant trends in performance and to compare performance over time;
- Methods for ensuring sustainability of improvements; and
- The hospice allocates sufficient resources to support continuous quality PIPs and activities.

PM 5.3 PIP activities and the selection of areas for improvement are determined based on data collected and input by employees, volunteers, leadership, and third-party survey administrators.

PM 5.4 A desired performance outcome is established and quantified for each performance improvement activity to enable measurable results.

PM 5.5 Plans are established in writing detailing the actions to be taken to achieve the desired performance outcomes.

PM 5.6 Changes in the organization's programs and processes are planned, piloted, implemented, and evaluated.

PM 5.7 Process changes are evaluated for performance and achievement over time with results communicated throughout the hospice.

PM 5.8 The hospice maintains documented evidence of each performance improvement project in its portfolio along with the reasons for conducting the projects, measurable progress achieved, and the results of monitoring for sustained improvement.

Practice Examples:

- Performance improvement project teams include staff directly involved in the processes targeted for improvement.
- The hospice utilizes an established performance improvement model for improving processes within the hospice program (e.g., The Institute for Healthcare Improvement's (IHI) Model for Improvement [Plan Do Study Act or PDSA], FOCUS-PDCA [Find, Organize, Clarify, Understand, Select – Plan, Do, Check, Act], FADE [Focus, Analyze, Develop and Execute], IDEAS [Investigate, Design, Execute, Adjust], Joint Commission's Framework for Improving Performance design, LEAN, Six Sigma, Adaptive Design).
- The hospice's selection of performance improvement projects is based on current measurable quality indicator trends.
- The hospice uses "story boards," bulletin boards, and other communication methods to display the results of data collected and improvements achieved.
- The hospice can demonstrate measurable sustained improvements for patient care outcomes and processes based on performance improvement activities.
- A summary report from each improvement team is submitted to the hospice's quality committee or council and includes evidence of realized improvements.

Standard:

PM 6: The hospice participates in government mandated quality reporting programs and voluntary quality reporting initiatives sponsored by the state and other organizations.

PM 6.1 The hospice submits accurate and timely data to federal, state, and other entities for the purpose of contributing to the development of quality databases and ensuring the availability of hospice provider quality comparison data.

PM 6.2 Staff is trained in accurate and timely generation, documentation, and extraction of quality data elements. Completeness and accuracy of data processes are systematically monitored.

PM 6.3 The hospice has a mechanism in place for periodic aggregation and reporting of quality data internally and to federal, state, and other entities on an ongoing basis. This includes allocation of sufficient resources and personnel to ensure that reporting is timely, relevant, and accurate.

PM 6.4 The hospice incorporates data and results from mandatory and voluntary quality initiatives into its QAPI program activities.

Practice Examples:

- The hospice participates in NHPCO's Quality Connections Program.
- The hospice routinely responds to NHPCO's requests to submit quality data (e.g., Survey of Team of Attitudes and Relationships (STAR) staff satisfaction survey and evaluation of care surveys).
- The hospice participates in federal, state, or local efforts to collect and analyze data across hospice organizations.

- The hospice routinely monitors quality measure results derived from quality data submitted to CMS and carries out performance improvement projects based on those data as indicated.
- The hospice utilizes available performance measure comparison results to identify improvement opportunities. The results are also reviewed for potential best practices that should be promoted, implemented, and maintained.



NHPCO
Performance Measures

NHPCO Performance Measures

Overview

A system of performance measurement is essential to quality improvement and needs to be a component of every hospice organization's quality strategy. For optimal effectiveness, performance measurement results should include internal comparisons over time as well as external comparisons with peers. Participation in NHPCO's performance measures provides activity credit in our Quality Connections program.

NHPCO offers a comprehensive set of performance measures that yield useful, meaningful, and actionable data. NHPCO provides on-demand provider level results for these performance measures and some comparative reporting of results as a member benefit. In addition, NHPCO is engaged in the development of new performance measures as well as the ongoing refinement and enhancement of current measures.

NHPCO provides online data submission, provider-level reporting, and comparative reporting for the following tools: Measures of Excellence (MOE); Evaluation of Grief Support Services (EGSS) (formerly FEBS, the Family Evaluation of Bereavement Services); and the Survey of Team Attitudes and Relationships (STAR). All of NHPCO's performance measurement assessments are valuable organization and program performance evaluation tools. These tools and subsequent reports allow an organization to identify areas of opportunity and potential correlations between opportunities, as well as develop the ability to track performance improvement in a timely and actionable manner.

Below are detailed descriptions of all our performance measures and tools:

- **Measures of Excellence (MOE)** – Measures of Excellence (MOE) is a quarterly data collection tool and dashboard that are important components of the Quality Connections program. The MOE tracks operational and clinical data to inform high quality care. The quarterly MOE Dashboard allows organizations to compare themselves to other organizations for benchmarking, enabling participants to identify performance improvement opportunities and track their performance improvement efforts. This comprehensive data collection and benchmarking report is an exclusive NHPCO member benefit.
- **Survey of Team Attitudes and Relationships (STAR)** – STAR is a job satisfaction tool designed specifically for the hospice field and related home care services (e.g., certified home health, palliative care, etc.). The upgraded product allows for comparison in real time with other organizations in addition to providing agency level reports. For more information on STAR, please see the NHPCO Performance Measures section of the NHPCO website.
- **Evaluation of Grief Support Services (EGSS)** – The EGSS survey is designed to evaluate bereavement services from the perspective of the recipients of the services. The survey takes a comprehensive approach by including questions on a wide range of services, many of them optional, so that hospices may tailor the EGSS survey to reflect the specific services they offer. The upgraded EGSS now allows for the survey to be sent electronically via email or by snail mail. The email option allows for automatic submission of the data. Manual entry by the hospice remains an option for the returned paper surveys. Organizations also have access in real time to the EGSS dashboard, including comparison to other organizations. Participation in EGSS is becoming more important as we advocate for reimbursement for community bereavement services. For more information on EGSS please see the [NHPCO Performance Measures section](#) of the NHPCO website.

NHPCO offers support for implementation, data collection and submission, and interpretation for all of the performance measures detailed above. Each performance measure's web page includes detailed information and guidelines for all aspects of the data collection and reporting process. In addition, NHPCO maintains a separate dedicated email address for each performance measure to answer any questions hospices may have:

- **MOE:** moe@nhpco.org
- **EGSS:** egss@nhpco.org
- **STAR:** star@nhpco.org
- **POM:** pom@nhpco.org
- **For general research inquiries:** quality@nhpco.org



Appendix I:
Hospice Inpatient
Facility (HIF)

Appendix I: Hospice Inpatient Facility (HIF)

Introduction

The principles and standards in all chapters of the Standards of Practice for Hospice Programs apply to hospice care in all care environments. The Hospice Inpatient Facility Appendix contains additional principles and standards that apply only to hospices that operate an owned or leased inpatient facility intended to provide hospice patients with the general inpatient (GIP) level of care.

This appendix applies to GIP level of care. For patients on routine home care (RHC) level of care, please refer to the Hospice Residential Care Facility (HRCF) appendix. Hospices that operate an owned or leased inpatient facility must comply with applicable federal, state, and local health and safety laws, regulations, and codes unless specific waivers have been granted by the appropriate regulatory authorities. The inpatient facility and its staff must be appropriately licensed and as applicable, certified to provide inpatient care.

Patient and Family/Caregiver-Centered Care (HIF PFC)

Standard:

HIF PFC 1: Nursing services are available on-site twenty-four (24) hours a day, seven (7) days a week to meet the patient's nursing needs in accordance with the hospice GIP level of care and the patient's individualized plan of care.

HIF PFC 1.1 A registered nurse (RN), knowledgeable and competent in providing direct care to hospice patients, is available on-site twenty-four (24) hours a day, seven (7) days a week. Each patient must receive all nursing services as prescribed in the plan of care and must be kept comfortable, clean, well groomed, and protected from injury.

HIF PFC 1.2 Other nursing staff including RNs, advanced practice nurses (APRNs/NPs), licensed practical nurses (LPNs) or licensed vocational nurses (LVNs), or hospice aides (titles as defined by applicable law) are available to ensure that each patient's medical needs are met in a timely, compassionate, and professional manner.

HIF PFC 1.3 The hospice has established policies regarding 24-hour nursing services to meet the patient's skilled needs in accordance with the inpatient level of care and the patient's individualized plan of care.

- Staffing for all services reflects the hospice's volume of patients, patients' acuity, and the level of service intensity for patients to ensure that plan of care outcomes are achieved and that negative outcomes are avoided.
- Each shift must include a RN who provides direct patient care if at least one patient in the hospice facility is receiving GIP care.

Practice Examples:

- Nurses received orientation to the hospice philosophy of care and symptom management.
- Nurse orientation and continuing education includes training about individualizing the patient's plan of care.

Standard:

HIF PFC 2: The hospice interdisciplinary team (IDT) must include individuals who work together to meet the physical, psychosocial, emotional, and spiritual needs of the patients and families/caregivers facing terminal illness and bereavement.

HIF PFC 2.1 Emotional, psychosocial, and spiritual care are provided by members of the hospice interdisciplinary team and/or counselors or social workers directly assigned to the hospice inpatient facility.

Practice Examples:

- A social worker is assigned to the hospice inpatient facility to address the emotional and psychosocial needs of each patient and family/caregiver.
- A social worker is assigned to the hospice inpatient facility to address the discharge planning and continuity of care needs of each patient and family/caregiver.
- Chaplains/spiritual caregivers are assigned to the hospice inpatient facility to address the spiritual needs of each patient and family/caregiver.
- A written schedule for after hours and weekend availability demonstrates that social worker and chaplain/spiritual caregiver services are available to address patient and family/caregiver needs.
- A bereavement counselor is available to provide services to family members/caregivers in need of additional support to cope with anticipatory grief and to prepare for the patient's death.

Standard:

HIF PFC 3: The hospice inpatient facility provides services designed to meet the unique nutritional needs of each hospice patient.

HIF PFC 3.1 Dietary counseling, when identified as a necessity in the plan of care, includes education and interventions provided to the patient and family/caregiver regarding appropriate nutritional intake as the patient's condition changes.

HIF PFC 3.2 Meal planning and the timing of meals are discussed with each patient and adjusted, as reasonable and appropriate, according to each patient's preference, selection, and nutritional needs.

HIF PFC 3.3 Food and nutritional supplements are provided in accordance with the special dietary restrictions noted on the patient's plan of care.

HIF PFC 3.4 The hospice inpatient facility ensures that food is procured, stored, prepared, distributed, and served under sanitary conditions and in a manner that is appealing to each patient.

HIF PFC 3.5 Any patient requiring assistance with meal planning and/or feeding receives such assistance by staff, volunteers, family members, or caregivers.

HIF PFC 3.6 Dietary counseling, when identified as a necessity in the patient's plan of care, is provided by qualified individuals, which may include a registered nurse, dietician, or nutritionist.

Practice Examples:

- Meals are individually scheduled allowing for frequent small meals if desired by the patient.
- Trained volunteers or staff members are available during mealtimes to assist patients with feeding as needed.
- Special dietary requirements are noted on the patient's plan of care and food is ordered and provided accordingly.
- Food, including between meal snacks or nourishment is available twenty-four (24) hours a day, seven (7) days a week to address the patient's reasonable requests and needs, unless limited by dietary restrictions prescribed by a physician.
- If the dietary counseling 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. The dietitian or nutritionist must be a hospice employee.

Standard:

HIF PFC 4: The hospice inpatient facility assures that all medications and treatments are available as ordered to meet each patient's needs and are dispensed and administered in accordance with all applicable federal and state laws and regulations.

HIF PFC 4.1 A licensed physician (or legal designee) orders all medications and treatment for each patient receiving hospice GIP care, in accordance with the plan of care and applicable state and federal laws.

HIF PFC 4.2 Verbal/telephone physician orders are received, immediately recorded, and read back by the licensed individual. The prescribing physician signs and dates the order in accordance with applicable laws and regulations.

HIF PFC 4.3 Medications are administered in accordance with applicable laws and regulations and in accordance with each patient's individual medication record developed as part of the hospice plan of care.

HIF PFC 4.4 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 pharmacist's services must include evaluation of a patient's response to medication therapy, identification of a potential adverse drug reaction, duplicative or ineffective therapy, and recommendation of appropriate corrective actions.

HIF PCF 4.5 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 professionals in accordance with their scope of practice and state laws;
- An employee that has completed a state approved training program in medication administration; and
- The patient who may self-administer medications upon approval by the hospice physician or patient's chosen attending physician.

Practice Examples:

- The hospice inpatient facility has a process to ensure timely signing and receipt of verbal orders.
- Medications are administered in accordance with physician orders and at the scheduled frequency.
- The hospice inpatient facility has a process for obtaining required medications in a timely manner twenty-four (24) hours a day, seven (7) days a week.
- A medication administration record is maintained for each patient and every administered medication is documented.
- Infusion pumps have free flow protection and audible alarms.
- A medication reconciliation process is in place.
- The facility has a process for reporting medication events, such as errors or missing medications, and implements corrective actions accordingly.
- The facility has a process for safe disposal of discontinued/unused medications and controlled substances in compliance with the hospice policy and in accordance with local, state, and federal requirements. The hospice maintains current and accurate records of the receipt and disposition of all controlled substances.

Standard:

HIF PFC 5: Death that occurs in the hospice inpatient facility is handled with respect and compassion toward the patient and family/caregiver.

HIF PFC 5.1 Postmortem policies and procedures are in place and minimally include:

- Compassionate care and preparation of the body in accordance with the desires of the patient and family/caregiver;
- Respect for any cultural or religious ritual or practice, spiritual traditions, beliefs relating to the death, and subsequent handling of the body and mourning of the family/caregiver;
- Allowance for family presence with the body as desired and for a reasonable amount of time after the patient's death;
- Provision of spiritual, psychosocial, or bereavement care or services as needed or desired by the family; and
- Provision for dignified removal of the body.

Practice Examples:

- Specific training is provided to the hospice inpatient facility staff on how to handle a patient death including information regarding respect for cultural and religious beliefs.
- Family members are afforded privacy with the patient's body as desired.
- Private meditation space is available for family members'/caregivers' use.
- Private exits are available for removal of bodies from the hospice inpatient facility.
- Policies and procedures permit families to remain for reasonable periods of time in patients' rooms following death.
- Private areas are available for the family's/caregiver's use following the death of a patient.
- Policies and procedures exist to ensure return of personal possessions to the appropriate individual, notify attending physician and family members/caregivers of the patient's death, and verify death in accordance with state and local requirements.

Ethical Behavior and Consumer Rights (HIF EBR)

Standard:

HIF EBR 1: Patients and families/caregivers are informed of eligibility requirements for the level of care being provided and the decisions, actions, and responsibilities to occur if a change in level of care is indicated.

HIF EBR 1.1 When a change in the patient's level of care is indicated, the patient and family/caregiver are informed of their choices and obligations, including financial responsibilities, if the patient remains in the hospice inpatient facility (HIF) and/or needs to move to another setting.

Practice Examples:

- Patients and responsible parties are informed of the purpose and short-term nature of GIP or respite level of care upon admission to that level of care.
- An Advance Beneficiary Notice (ABN), with explanations, is provided to the patient and family/caregiver when the patient no longer meets GIP criteria but wishes to remain at the HIF.
- Discussion with patient/responsible party of the change in levels of care and any relocation of the patient or charges incurred, such as room and board, is documented.
- Patients and responsible parties are informed of rights to appeal during the admission to services process.

HIF CES 1: Clinical Excellence and Safety (HIF CES)

Standard:

HIF CES 1: The hospice inpatient facility is designed to provide a homelike environment and offer patient areas designed to preserve the dignity, comfort, and privacy of patients.

HIF CES 1.1 The hospice inpatient facility decor is homelike in design and function.

HIF CES 1.2 The hospice inpatient facility has physical space and policies and procedures that assure:

- Patient and family/caregiver privacy;
- Accommodations for family members/caregivers to remain with the patient as desired;
- Unrestricted visitation privileges including children;
- Appropriate accommodations that provide for privacy;
- Appropriate safety measures to minimize patient falls; and
- If smoking is permitted it is limited only to designated areas away from patient care.

HIF CES 1.3 The hospice inpatient facility has physical space and equipment that addresses and supports:

- The patient's plan of care;

- Close proximity of the patient to toileting and bathing areas;
- Patient care space at or above grade level;
- Closet space for security and privacy;
- No more than two (2) beds in any single patient room;
- Space adequate to provide medical treatments and personal care, facilitate patient mobility, and comfortably accommodate visitors regardless of single or double occupancy of the room (room accommodations must meet applicable state regulations for room size);
- An adequate supply of hot water with plumbing control valves that automatically regulate temperature;
- Ability to support flexibility related to individual patient room temperatures; and
- An accessible, easily activated, consistently functioning device that is used for calling for assistance.

HIF CES 1.4 The hospice inpatient facility has linens available for appropriate care and comfort of patients. Linens are handled, stored, processed, and transported in compliance with applicable infection control standards, policies, and procedures.

HIF CES 1.5 The hospice inpatient facility has policies and procedures addressing the isolation of patients with infectious diseases and complies with applicable infection control standards, policies, and procedures.

Practice Examples:

- The hospice inpatient facility provides for semi-private accommodations that include curtain separations, partitions, or screens to create privacy and contain a private bathroom and shower.
- Patient accessible electronic media players and telephones are available.
- Furnishings, lighting, wall coverings, window treatments, and floor coverings are residential in appearance and design.
- Convertible patient furniture or portable "beds" are available for family members/caregivers.
- A bathroom and shower are available for family members/caregivers.
- A kitchen area is available that allows for family food preparation.
- Sufficient private gathering spaces are available to create an intimate environment for various purposes and numbers of people.
- Spaces exist that are designed to accommodate visiting children and their needs.
- Patient isolation policies and procedures exist which encourage as much normal patient functionality as possible and preserve patient dignity.
- The hospice inpatient facility has physical space and a plan which permits appropriate patient access to the outdoors.

Standard:

HIF CES 2: The hospice develops, implements, and evaluates a plan for emergency preparedness. A written emergency preparedness plan exists, is regularly communicated to staff through orientation and ongoing measures, and includes:

- A definition of an emergency event for the hospice inpatient facility's location and circumstances;
- Arrangements for prompt identification and transfer of patients and records to another facility if necessary;

- Arrangements for coordination of community resources; and
- Compliance with National Fire Protection Association (NFPA) Life Safety Code and other applicable regulations.

HIF CES 2.1 The hospice inpatient facility staff is oriented to life safety code features and equipment.

HIF CES 2.2 The hospice inpatient facility staff demonstrates and evaluates their proficiency in understanding the emergency preparedness plan by routine rehearsal.

HIF CES 2.3 The emergency preparedness plan is regularly evaluated for appropriateness and revised as necessary.

Practice Examples:

- The facility's electronic clinical record system or database is backed up to an off-site data storage facility for retrieval if onsite records are lost or corrupted.
- The facility conducts and documents an annual review of written fire safety and emergency preparedness plans.
- Transfer arrangements with other facilities are written and reviewed.
- Evacuation diagrams are posted and visible to all staff, patients, and family members/ caregivers.
- Rehearsals and critiques are conducted semi-annually for the emergency preparedness plan.
- Reasons to shelter in place versus evacuate are defined and the procedures for both are practiced.
- The facility has a back-up generator for short-term electrical generation.
- There is enough food onsite to provide sufficient nutrition for patients and staff for prolonged periods as applicable to state and federal laws or accrediting bodies.

Standard:

HIF CES 3: The hospice inpatient facility meets all federal, state, and local laws, and regulations and codes pertaining to health and safety, including the latest edition of the NFPA's Life Safety Code.

HIF CES 3.1 The hospice inpatient facility has been constructed and/or renovated to comply with applicable federal, state, and local laws, regulations, and codes.

HIF CES 3.2 The hospice inpatient facility is sufficiently equipped, maintained, and sanitized to care for admitted patients and to comply with applicable federal, state, and local laws, regulations, and codes.

HIF CES 3.3 The hospice inpatient facility has received the appropriate Centers for Medicare and Medicaid Services (CMS) waivers, if any, related to the Life Safety Code.

HIF CES 3.4 The hospice inpatient facility has a contract and appropriate policies and procedures related to disposal of biohazardous waste.

Practice Examples:

- A mechanism exists for staff to report equipment maintenance needs.
- A preventive maintenance program exists for heating, ventilation, and air conditioning (HVAC); electrical; sprinkler; and security systems.

- Announced and unannounced fire drills are regularly carried out. Fire alarm tests are scheduled on a regular basis.
- Fire extinguishing equipment, sprinkler systems, grease traps, and elevator testing and maintenance is regularly documented.
- A capital equipment replacement schedule is in place and included in budgeting process.

Standard:

HIF CES 4: The hospice inpatient facility provides for the appropriate storage and disposal of drugs and medications.

HIF CES 4.1 The hospice inpatient facility has separately locked compartments for Schedule II drugs.

HIF CES 4.2 The hospice inpatient facility has appropriate policies and practices for the review of discontinued, expired, or deteriorated drugs.

Practice Examples:

- Policies and procedures exist and are evaluated for the appropriate access to medication storage areas.
- A process is outlined for staff members, and they are educated on the proper counting and tracking of all drugs, especially controlled substances.
- A pharmacist regularly inspects drug ordering, storage, administration, disposal, and record keeping procedures.
- There is a Pharmacy and Therapeutics Committee with responsibility for facility medication management functions.
- Discrepancies in drug supply are reported and addressed promptly and in a consistent manner.
- Policies and procedures are established for the disposal of all drugs including compliance with disposal requirements for controlled substances, in compliance with federal, state and local laws.

Standard:

HIF CES 5: The hospice inpatient facility environment is safe, clean, and secure for patients, families/caregivers, volunteers, and staff.

HIF CES 5.1 The hospice inpatient facility has written policies and procedures that are communicated to staff and appropriate for the facility's location that address:

- Housekeeping procedures (follow federal/state regulations related to cleaning/disinfection procedures for COVID-19)
- Security measures;
- Visitor entrance procedures;
- Access to security and emergency personnel (e.g., police, security staff, sheriff, fire department, emergency medical technician (EMT), emergency psychiatric team);
- Inappropriate behavior that could harm others; and
- Monitoring of public areas.

HIF CES 5.2 The hospice inpatient facility has written policies and procedures to address the cleanliness and safety of the facility.

HIF CES 5.3 The hospice inpatient facility has a process to report, document, and evaluate safety and security incidents for corrective actions.

Practice Examples:

- Security staff ensures appropriate access to the facility and that entry areas are staffed.
- Electronic alarm, voice, or video systems exist to monitor the grounds and entrances.
- Visitor identification requirements are established and enforced.
- Electronic devices exist to summon authorities.
- Incidents are regularly reported and reviewed and systems are regularly assessed for needed change.
- Staff awareness programs exist to enforce and highlight security issues.
- Policies and procedures are available for dealing with family/caregiver or visitor behavior that is unacceptable and/or impedes patient care.
- Housekeeping of patient areas follows a defined process to ensure adequate infection control measures throughout the facility.
- Housekeeping staff are regularly available and a 24-hours per day plan exists for meeting patients' housekeeping needs.
- Resource agreements are written and reviewed for ongoing and emergency service for major cleaning needs.
- Records are retained demonstrating that any draperies have been treated to be flame retardant.

Standard:

HIF CES 6: All patients have the right to be free from physical and mental abuse and corporal punishment.

HIF CES 6.1 Seclusion and restraints may only be used when ordered by a physician and needed to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at the earliest possible time. Seclusion and restraints may only be used in accordance with state law and only when less restrictive interventions have been deemed ineffective.

HIF CES 6.2 All patient care staff working in the inpatient facility must have training and demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and care provision for a patient in seclusion or restraints per physician order specifications, organizational policy, and procedures. Staff must also be certified in cardiopulmonary resuscitation (CPR).

HIF CES 6.3 Hospices must report deaths associated with the use of seclusion or restraints in accordance with state and federal regulations.

HIF CES 6.4 An inpatient facility may be restraint and seclusion free. If the inpatient facility is restraint and seclusion free, the facility must have an applicable policy which includes care provisions for a patient requiring restraint or seclusion.

Practice Examples:

- The hospice provides staff orientation and ongoing training related to physical and chemical restraints and patient seclusion.
- The hospice has a policy addressing alternative treatments or settings to manage patients that are violent or have self-destructive behavior.

HIF IA 1: Inclusion and Access (HIF IA)

Standard:

HIF IA 1: Access to hospice GIP care is available to all hospice patients who need acute inpatient pain control or symptom management that cannot be provided in other settings and who meet the general admission criteria to a hospice program.

HIF IA 1.1 The hospice patient has a right to participate in the decision-making process regarding available locations for the delivery of inpatient level of care and to choose their attending physician.

HIF IA 1.2 The hospice has additional option(s) available for GIP care other than the hospice inpatient facility.

Practice Examples:

- The hospice utilizes written criteria that meet regulatory guidance for admission to and continued stay in the hospice inpatient facility.
- The hospice offers options for GIP stays for each patient, which includes, but is not limited to, an inpatient stay in the hospice's owned inpatient facility or at a contracted hospital or skilled nursing facility.

Organizational Excellence (HIF OE)

Standard:

HIF OE 1: The HIF is included in agency-wide strategic planning and participates in activities to meet these goals.

Practice Examples:

- There is a representation of the hospice inpatient facility in the strategic planning meeting.
- Objectives for the HIF have input from one or more representatives of the HIF.
- Strengths and weaknesses of the HIF are utilized in the strategic planning process.

Workforce Excellence (HIF WE)

Standard:

HIF WE 1: The 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 pharmacist services include:

- Evaluation of the patient's response to medication therapy;
- Identification of potential adverse drug reactions, duplicative, or ineffective therapy; and
- Recommended appropriate corrective action.

Compliance With Laws And Regulations (HIF CLR)

Standard:

HIF CLR 1: The hospice identifies and ensures compliance with all federal, state, and local regulations that apply to the operation of an inpatient facility and/or the licensure of the facility itself.

Practice Examples:

- Staff education is provided in orientation and on an ongoing basis on regulations related to operating an inpatient facility.
- Regulatory mock surveys are conducted periodically and results are used for improvement.
- Policies and procedures are in place and readily available which support the regulations.

Stewardship And Accountability (HIF SA)

Standard:

HIF SA 1: Funds donated specifically for use at the inpatient facility are acknowledged and procedures are in place to ensure use meets donor wishes.

Practice Examples

- Procedures are in place within the hospice to differentiate and acknowledge when funds are specifically donated for the inpatient facility whether in general or for specific requests.
- A report is provided annually noting all funds specified for the inpatient facility and how specific wishes were met.

Performance Measurement (HIF PM)

Standard:

HIF PM 1: The HIF is included in the agency-wide Quality Assurance and Performance Improvement (QAPI) program.

Practice Examples

- The annual comprehensive QAPI program plan submitted to the governing body includes quality indicators reported separately for the inpatient facility.
- The hospice quality committee or council identifies high priority targets for performance improvement which include the inpatient facility measurable indicators.
- The inpatient facility customer service concerns are a part of the QAPI program.
- The inpatient facility incidents are a part of the QAPI program.
- The inpatient facility infections are a part of the QAPI program.

HIF PM 2: The HIF identifies performance improvement opportunities and demonstrates participation in performance improvement projects (PIPs).

Practice Examples

- The hospice quality committee or council includes a representative from the inpatient facility to identify and oversee performance improvement activities that include activities which are pertinent to the hospice inpatient facility.
- The hospice considers benchmarking with other (outside their own CCN) hospice inpatient facilities.
- Performance improvement activities which include an inpatient facility component are developed and implemented with input of inpatient facility staff.



Appendix II:
Nursing Facility Hospice
Care (NF)

Appendix II: Nursing Facility Hospice Care (NF)

Introduction

The principles and standards in each chapter of the Standards of Practice for Hospice Programs apply to hospice care provided in all care environments. The Nursing Facility Hospice Care Appendix outlines additional principles and standards that apply only to hospices providing care to individuals residing in a nursing facility that delivers primary caregiver services predominantly hired by the facility. The Nursing Facility Hospice Care Appendix does not apply to individuals receiving skilled nursing care in a facility. The term "nursing facility" includes skilled nursing facilities (SNF), nursing facilities (NF), and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

The hospice will comply with all applicable federal, state, and local health and safety laws, regulations, and codes, unless the appropriate regulatory authorities have granted specific waivers. The nursing facility and its staff will be appropriately licensed and as applicable, certified to provide this level of service.

NF PFC 1: PATIENT AND FAMILY/CAREGIVER-CENTERED CARE (NF PFC)

Standard:

NF PFC 1: The hospice assumes professional management responsibility of hospice services provided to residents of nursing facilities in accordance with the hospice plan of care.

NF PFC 1.1 The hospice ensures that all care and services routinely offered to home patients are also offered and available to patients whose residence is a nursing facility.

NF PFC 1.2 The hospice demonstrates collaboration with the facility partner to ensure a coordinated plan of care.

Practice Examples:

- The hospice RN coordinates the patient's care by ensuring the plan of care contains all needed services as identified by the IDG assessments.
- The hospice ensures the current advance directive is available in the NF record.
- The hospice reviews the NF care plan for alignment with the advance directives.
- A process to determine if any medications are unrelated is followed, documented and communicated to the NF.
- The NF patient medication list is reviewed at each skilled nursing visit to determine if any new medications have been added without the hospice knowledge and then discussed with NF staff.

Standard:

NF PFC 2: The hospice develops a hospice plan of care in consultation with the nursing facility staff and the patient and family/caregiver.

NF PFC 2.1 The hospice and the facility collaboratively develop and document a coordinated plan of care for each patient that guides both providers and is in accordance with any federal, state, or local laws and regulations for the facility and the hospice.

NF PFC 2.2 Both the hospice and facility care plans should contain the same problems and goals when laid side by side. Interventions are complementary and reflect palliative rather than curative care.

NF PFC 2.3 The plan of care should reflect patient and family/caregiver goals and include interventions based on the problems identified in the initial comprehensive and updated assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions.

NF PFC 2.4 The plan of care should specify appropriate delegation of responsibilities for provision of hospice care and non-hospice services by delineating which provider and discipline is responsible for performing each function related to the patient's care. The hospice staff routinely reviews the nursing facility's plan of care and communicates and coordinates with the nursing professional who completes the minimum data set (MDS), and other facility nursing leadership as designated.

NF PFC 2.5 The hospice works with the nursing facility staff and the patient and family/caregiver to ensure that all changes to the plan of care are discussed and mutually agreed upon prior to implementation.

NF PFC 2.6 The hospice nurse case manager is responsible for the coordination of the hospice services for each hospice patient residing in a nursing facility. The plan of care should be communicated by the nurse case manager or other hospice staff to the facility staff and other health care providers.

NF PFC 2.7 The hospice communicates with the patient's attending physician, the nursing home medical director, and other physicians actively participating in the care of the patient to ensure coordination of the patient's hospice care with all other aspects of the patient's medical care.

NF PFC 2.8 Representatives from the hospice interdisciplinary team will participate in nursing facility/hospice care plan meetings whenever possible.

Practice Examples:

- There is one IDG member assigned to track when the NF care conference will be held so that one or more members of the IDG attends/participates in the NF care conference for each hospice patient.
- The Hospice has a checklist to utilize to ensure coordinated problems, goals and interventions on a routine basis.
- When the care plans are not aligned, there is a process to address with the NF MDS nurse and resolve.
- Processes are established in nursing facilities for the coordination of hospice care and services provided to hospice-enrolled nursing facility residents, with facility staff, the facility health care team, and the hospice interdisciplinary team.
- The nursing facility plan of care is integrated with the hospice plan of care and reflects collaborative efforts to address the care needs of the nursing facility resident enrolled in hospice and family/caregivers or representative.
- The hospice and the nursing facility develop a plan for communication about patient needs and changes.

- There is a defined dispute resolution process.
- The hospice plan of care includes the frequency and method of contact with the family based on family request.
- Hospice addresses any patient/family concerns voiced about the NF care through a defined process with the NF.

Standard:

NF PFC 3: The hospice provides the nursing facility at a minimum with copies of the following:

- Most recent hospice plan of care;
- Hospice election form;
- Advance directive, as appropriate, including the Health Care Power of Attorney and/or medical surrogacy information;
- Physician certification and recertification of the terminal illness which includes the brief physician narrative;
- Name and contact information for hospice personnel involved in hospice care for each patient;
- Instructions for accessing the hospice's 24-hour on-call system;
- Hospice medication information specific to each patient; and
- Hospice physician and attending physician orders.

PFC 3.1 Information already on file regarding advance directives, medical surrogacy, and/or funeral arrangements shall be provided to the hospice by the nursing facility.

Practice Examples:

- Hospice has a process with assigned responsibility to provide copies of the most recent plan of care (any time there are changes) and physician orders when obtained.
- At the beginning of each new benefit period, there is a process to provide a copy to the NF of the certification.
- There is a process developed with the NF where the required copies will be stored or scanned into a specific file.
- Periodic audits will be performed to ensure the required copies are in the NF record.

Standard:

NF PFC 4: Caregivers in a nursing facility will have access to hospice staff 24 hours a day, 7 days a week and hospice staff will have access to the nursing facility's staff 24 hours a day, 7 days a week.

NF PFC 4.1 Hospice demonstrates evidence there is communication and collaboration with the nursing facility staff, as appropriate, and documents communication.

NF PFC 4.2 Spiritual/psychosocial issues after hours and on weekends may be addressed by after hours and weekend staff and relayed to the hospice interdisciplinary team for further follow-up.

NF PFC 4.3 Hospice provides the nursing home with information regarding the date and time to expect visits from members of the hospice interdisciplinary team.

Practice examples:

- Hospice has a process to provide planned visit calendar to NF weekly.
- There is a standard process followed by all hospice staff where/who to check in and out with on each visit.
- Twenty-four-hour phone number for hospice is noted in each record for emergency and routine contact.
- Routine visits by all IDG are made on the weekend as needed.
- Any change in condition including falls, will result in a visit regardless of day or hour.
- On-call tracking is reviewed to determine if the appropriate visits are made after notification of change in condition.
- When hospice assesses the need for a medication change, SN will follow up to obtain order, ensure order has been communicated to NF and that medication is delivered. A follow up visit will be made timely to assess effectiveness.

Standard:

NF PFC 5: The hospice has a plan for providing bereavement care to identified nursing facility staff and residents as appropriate.

Practice examples:

- Hospice has a process to identify when there is a need for bereavement services to staff and residents.
- Memorial services are held periodically in the NF.
- Roommates and table mates are identified for bereavement support.

Standard:

NF PFC 6: The hospice interdisciplinary team ensures that the nursing facility patient receives the appropriate level of care and services.

NF PFC 6.1 A well-coordinated transition to another level of care or setting is facilitated by the hospice interdisciplinary team when a change in the patient's condition requires an adjustment in hospice level of care and services.

NF PFC 6.2 The hospice interdisciplinary team is responsible for coordination of appropriate end-of-life care in cooperation with the nursing facility and in accordance with federal and state regulations.

Practice Examples:

- Specific training is provided to the nursing facility staff to manage a patient death, including information regarding respect for cultural and religious beliefs.
- Family members are afforded privacy with the patient's body as desired.
- Private meditation space is available for family members/caregivers' use.

- Policies and procedures permit families to remain for reasonable periods of time in patients' rooms following death.
- An area that affords privacy is available for the family's use following the death of a patient.
- The nursing facility and hospice collaborate to develop and update the patient's coordinated plan of care.
- The hospice and nursing facility have a process by which information from updated hospice assessments and nursing facility patient/family/caregiver information is exchanged.
- The hospice establishes a policy for provision of complementary services (as available) to patients in collaboration with the nursing home staff.
- The hospice social worker partners with the nursing facility social worker to educate the patient and family/caregiver regarding advance directive information, treatment decisions, and funeral arrangements.
- The hospice social worker partners with the nursing facility social worker in completing applications for Medicaid eligibility as needed.
- The hospice interdisciplinary team assesses family members/caregivers' reactions/concerns regarding a patient's transition to a location of care other than his/her personal residence and facilitates discussion of those concerns.
- The hospice interdisciplinary team assists the patient and family/caregiver in identifying nursing facility placement options and financial planning for payment of nursing facility care.
- Nursing facility staff is invited to attend and participate in hospice interdisciplinary team meetings when the needs of a patient residing in the nursing facility will be discussed.
- The hospice medical director discusses coordination of hospice care services with the nursing facility medical director as needed.
- Hospice staff members communicate with nursing facility staff and pharmacy about Medicare Part D payment for medications that are not related to the terminal prognosis and ensures that the hospice will be billed for any medications related to the terminal prognosis.
- The hospice volunteer program includes a component for volunteer assignments for patients residing in a nursing facility, especially for those with no family members nearby.
- Volunteer orientation and training includes appropriate components for assignment to patients residing in nursing facilities.
- Hospice staff members attend the nursing facility's care planning meetings for hospice patients.
- The record of each hospice patient in a nursing facility has the hospice's name and telephone number prominently displayed. Instructions related to on-call availability and when to contact the hospice is contained in the record in an easily accessible place.
- Nursing facility staff members on all shifts receive training regarding the availability of after- hours and/or on-call services for hospice patients.
- The hospice offers to facilitate annual memorial services for nursing facility patients who have died as the need is identified.
- Hospice bereavement services are offered to nursing facility staff and residents on an ongoing basis.
- All communication with the nursing facility is documented in the patient's facility medical records and the hospice clinical record.

- After-hours/weekend call logs document communication to and from nursing facilities.
- The hospice and nursing facility have a process by which information from the hospice interdisciplinary team plan of care is reviewed and updated and can be found in both the hospice and nursing facility clinical records.
- For facility residents who are enrolled in hospice, documentation in the patient record demonstrates collaboration and communication by hospice team members and facility staff, and the plan of care is revised in response to the patient and family/caregiver reassessment.
- The nursing facility plan of care is integrated with the hospice plan of care and reflects collaborative efforts to address the care needs of the hospice enrolled nursing facility resident, the family representative, and facility staff.

NF EBR 1: ETHICAL BEHAVIOR AND CONSUMER RIGHTS (NF EBR)

Standard:

NF EBR 1: The hospice fully complies with the federal anti-kickback statute that prohibits personnel and representatives from knowingly and willfully offering, paying, requesting, or receiving money or other benefits directly or indirectly from third parties in connection with items or services billed to federal programs.

NF EBR 1.1 The hospice does not submit or cause to be submitted to federal healthcare programs claims for patients who were referred pursuant to contracts or financial arrangements that were designed to induce such referrals in violation of the anti-kickback statute or similar federal or state statutes or regulations.

NF EBR 1.2 The hospice does not engage in activity in violation of the state or federal regulations in which gifts or services are provided in return for referrals or future consideration.

NF EBR 1.3 The hospice will develop internal policies and procedures in accordance with applicable laws and regulations as evidenced by the compliance program.

Practice Examples:

- Hospice staff members ensure items provided to nursing facility staff are within established dollar limits (e.g., provides pens or other items to the nursing facility staff for promotional reasons).
- Hospice staff members present in-service education on hospice related topics for nursing facilities without additional incentives (e.g., extravagant meals, staff gifts, facility gifts).
- Continuing education credit is provided only for a reasonable cost (e.g., not provided for free).
- Education is provided by the hospice for nursing facility staff only as it relates to the care of hospice patients.
- Services purchased through a nursing facility are at fair market value.
- Hospice aide services in nursing facilities are offered at the same frequency and duration as such services are provided in patients' homes. The hospice aide supplements the services of the facility certified nursing assistant.

NF CES 1: CLINICAL EXCELLENCE AND SAFETY (NF CES)

Standard:

NF CES 1: The hospice and nursing facility collaborate to ensure safety and clinical excellence of care for hospice patients residing in the facility.

NF CES 1.1 The hospice and nursing facility collaborate on identifying safety risks and develop a plan to address identified risks.

NF CES 1.2 Hospice and nursing facility staff collaborate to improve operational processes and deliver coordinated clinical care.

Practice Examples:

- The hospice staff members maintain an awareness of and participate as appropriate in the nursing facility safety program as it relates to:
 - fall prevention;
 - infection control;
 - hazardous material and waste;
 - fire and evacuation plans;
 - emergency/disaster preparedness plans; and
 - communication contingency plans.
- Incidents and accidents are reported and monitored by both the hospice and the nursing facility, and joint plans of correction are developed, when indicated.
- Hospice staff members 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 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) administrator within 24 hours of the hospice becoming aware of the alleged violation, or as defined by state regulations which may require more stringent reporting timelines according to the type of violation.
- The process for hospice provision of durable medical equipment in the nursing facility is clearly communicated and coordinated with the facility.
- The hospice durable medical equipment provider instructs the nursing facility and hospice staff in the proper use of any delivered equipment.
- The hospice and nursing facility utilize risk assessment tools to determine the patient's level of risk for falls and wounds.
- The hospice staff members are educated on infection control measures in the nursing facility, (e.g., hand washing, infection reporting, and isolation procedures).
- The hospice participates in the nursing facility infection control and safety review evaluation and includes the information in the hospice quality program.
- Hospice staff reports potential patient safety hazards and collaborates with the nursing facility to improve patient safety, including strategies for falls reduction.

NF IA 1: INCLUSION AND ACCESS (NF IA)

Standard:

NF IA 1: The hospice patient or the patient's representative has a right to participate in the decision-making process regarding care and treatment.

Practice Examples:

- A routine procedure for communication with the patient's representative is implemented when the patient does not have decision making capacity.
- The patient or patient's representative is contacted before there is a change in the plan of care unless delay in implementing the change would have a negative impact on the patient's condition.

NF OE 1: ORGANIZATIONAL EXCELLENCE (NF OE)

Standard:

NF OE 1: The hospice demonstrates professional management of the patient's hospice care services in accordance with the hospice/nursing facility coordinated plan of care.

Practice Examples:

- The hospice nurse case manager manages the plan of care with input from the patient, family/caregiver, and nursing facility and coordinates the implementation of the plan with the nursing facility staff.
- Hospice identifies a specific member of the hospice core team to communicate with the nursing facility staff on a regular basis to evaluate:
 - the needs of the hospice patient and the nursing facility staff; and
 - the implementation/updating of the plan of care.
- The hospice nurse case manager reviews the nursing home and hospice care plans and documents communication, coordination, and collaboration of the hospice and nursing home care plans on a regular ongoing basis.

NF WE 1: WORKFORCE EXCELLENCE (NF WE)

Standard:

NF WE 1: The hospice provides orientation and training to nursing facility staff.

NF WE 1.1 The hospice demonstrates that nursing facility staff on all shifts are offered education in the hospice philosophy, hospice policies and procedures, symptom management, death and dying, patient rights, and record keeping requirements.

NF WE 1.2 The hospice staff are trained in the principles of long-term care including the assessment and management of frail elders, collaborative care planning and nursing home systems, rules and regulations.

Practice Examples:

- The hospice attempts to hire staff with nursing facility experience.
- Hospice staff orientation includes education related to nursing facility requirements and environment.
- The hospice provides in-service training to nursing facility staff about the reasons to contact the hospice immediately.
- The hospice provides in-service training to nursing facility staff on the topics of work-related grief and loss and end-of-life care.
- The hospice responds to questions concerning hospice patients during the nursing home survey process and provides nursing home surveyors with documentation from the hospice patient records as well as answers questions regarding hospice services.
- Orientation to hospice care is included in the nursing facility's orientation program.
- The hospice collaborates and coordinates educational offerings related to hospice and end-of-life care with the nursing facility's education coordinator.

NF CLR 1: COMPLIANCE WITH LAWS AND REGULATIONS (NF CLR)

Standard:

NF CLR 1: The hospice and nursing facility have a written agreement specifying each party's responsibilities for hospice patients residing in the nursing facility.

NF CLR 1.1 The written agreement includes:

- A delineation of the hospice's responsibilities and nursing facility responsibilities;
- Method of communication between hospice and nursing facility staff to ensure that the needs of patients are met 24 hours/day;
- A provision that the nursing facility immediately notify the hospice if:
 - there is a significant change in the patient's status;
 - the plan of care needs to be altered;
 - the patient needs to be transferred to an alternate care setting or needs a level of care change; or
 - the patient dies.
- A provision noting that it is the Hospice's responsibility to determine the appropriate course of hospice care including determining the level of care and changes to the level of care;
- A provision that the nursing facility continues to provide the same level of care to the patient as before hospice was provided;

- A provision that the hospice will provide the same level of services as if the patient was in their own home;
- A provision that the hospice must report to the nursing facility administrator all alleged mistreatment, neglect, or abuse by anyone unrelated to the hospice within 24 hours of becoming aware of the alleged violation, or as defined by state regulations which may require more stringent reporting timelines according to the type of injury; and
- A delineation of the hospice's responsibility to provide bereavement services to the nursing facility staff.

Practice Example:

- The following documents are provided to the nursing facility for each resident for whom the hospice is providing services:
 - An up-to-date hospice plan of care;
 - Hospice election form and any advance directives;
 - Physician certification and recertification of the terminal illness;
 - Names and contact information for hospice personnel involved in the patient's care;
 - Instructions on how to access the hospice's 24-hour on-call system;
 - Hospice medication information; and
 - Hospice physician and attending physician (if any) orders.

NF SA 1: STEWARDSHIP AND ACCOUNTABILITY (NF SA)

Standard:

NF SA 1: The hospice staff members follow an established code of conduct, act in a professional manner, and observe the regulations governing both the hospice and the nursing facility.

Practice Example:

- The hospice has an effective compliance program that includes a code of conduct acknowledged by all hospice staff.

NF PM 1: PERFORMANCE MEASUREMENT (NF PM)

Standard:

NF PM 1: Hospice quality assessment and performance improvement efforts are inclusive and reflective of services provided in all settings.

Practice Examples:

- The hospice tracks falls, infections, medication errors, and other adverse events of patients residing in a nursing facility who receive hospice services and monitors and addresses trends.
- The nursing facility and hospice share information on their performance improvement programs and current performance improvement initiatives as appropriate.



Appendix III:
Hospice Residential Care
Facility (HRCF)

Appendix III: Hospice Residential Care Facility (HRCF)

Introduction

The principles and standards in all chapters of the Standards of Practice for Hospice Programs apply to hospice care provided in a hospice residential care facility. The Hospice Residential Care Facility Appendix contains additional principles and standards that apply only to hospices that operate an owned or leased residential care facility intended to provide hospice patients with the routine or continuous levels of care. The facility offers discrete private living arrangements for hospice-appropriate patients for whom the hospice takes on primary caregiving responsibility. The standards contained in this Appendix are intended to apply to facilities operated as an owned or leased facility by a hospice.

Patients in such a facility will be encouraged to maintain and develop their fullest potential for independent living through participation in planned activities for as long as they are able or desire to do so. The activities made available may include: socialization achieved through activities such as discussion and conversation, recreation, arts and crafts; daily living skills/activities which foster and maintain independent functioning; leisure time activities cultivating personal interests and pursuits; physical activities and free time so residents may engage in activities of their own choosing.

Recognizing that regulations and licensure rules vary from state to state, hospices that operate an owned or leased hospice residential care facility must comply with applicable federal, state, and local health and safety laws, regulations, and codes unless specific waivers have been granted by the appropriate regulatory authorities. The hospice residential care facility and its staff will be appropriately licensed and, as applicable, certified to provide hospice care.

HRCF PFC 1: PATIENT AND FAMILY/CAREGIVER-CENTERED CARE (HRCF PFC)

Standard:

HRCF PFC 1: Nursing services are available to meet the patient's nursing needs in accordance with the hospice plan of care.

HRCF PFC 1.1 A registered nurse experienced in providing direct care to hospice patients is available on site or on-call twenty-four (24) hours a day, seven (7) days a week.

HRCF PFC 1.2 A hospice aide is on site 24 hours a day with increased levels of staffing consistent with the acuity of the patients and their plans of care.

HRCF PFC 1.3 Prior to admission and throughout the patient stay, patients are evaluated against written criteria to assess the program's capability of providing the appropriate level of care.

Practice Examples:

- Documentation provides evidence of registered nurse (RN) supervision of other nursing staff providing care (e.g., licensed vocational nurse /licensed practical nurse (LPN/LVN), hospice aide) per federal/state regulations.
- Assessment and transfer policies and procedures direct when a patient's needs and plan of care cannot be met at the level of care at the facility.
- A transfer summary is generated with detailed information when a patient transfers to or from the hospice residential care facility.
- Policies and procedures are in place to determine the amount of supervision necessary for patients who wander, patients who are confused or forgetful, for social activities, and for patients who choose to manage their own financial resources.
- A program is implemented to provide training and supervision for volunteer sitters who may be assigned, as needed, to provide reassurance and companionship to the patient or to maintain safety.
- The hospice residential care facility has a plan for transfer of patients to an appropriate facility when discharged from hospice care but unable to live independently.
- The hospice physician assumes primary care for the hospice residential care facility patient if the patient's chosen attending physician does not wish to assume the responsibility.
- The environment is maintained in a manner that promotes safety, infection control, visitors, and rest and nighttime sleep for the residents.

Standard:

HRCF PFC 2: Psychosocial, spiritual care, and non-core services is available to meet the needs of each patient and family/caregiver receiving hospice residential care.

HRCF PFC 2.1 Psychosocial and spiritual care is provided by qualified members of the hospice interdisciplinary team and/or counselors or social workers.

HRCF PFC 2.2 Non-core services such as physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) are arranged for and provided by the hospice as indicated by patient needs.

Practice Examples:

- A social worker is assigned to provide services at the hospice residential care facility to address the psychosocial needs of the patient and family/caregiver.
- Chaplains/spiritual care counselors are trained in hospice care attend to the spiritual needs of patients and families at the hospice residential care facility.

- Patients and families/caregivers are assessed for adjustment to the new environment within a few days following admission to the hospice residential care facility.
- A written schedule of after normal business hours availability demonstrates that social worker and chaplain/spiritual caregiver services are available to meet patient needs.
- Patient and family/caregiver requests for visits by clergy of all religions are accommodated and welcomed.
- Celebration of all religious holidays is respected and recognized as appropriate.
- Art, music, and pet therapies are available to the hospice residential care facility patient.
- Volunteers are assigned to the hospice residential care facility to address administrative and patient support needs (e.g., receptionist services, passing meal trays, coordinating activities).

Standard:

HRCF PFC 3: The hospice residential care facility ensures that all medications and treatments are available, as ordered, to meet each patient's needs and are dispensed and administered in accordance with all applicable laws, regulations, and codes.

HRCF PFC 3.1 All medications for each patient receiving hospice residential care must be prescribed in accordance with all applicable laws, regulations, and codes.

HRCF PFC 3.2 Verbal orders are received in accordance with all applicable laws, regulations, and codes and immediately recorded, signed, and dated by the prescriber in accordance with all applicable laws, regulations, and codes. A procedure for verbal order read-back is implemented to ensure accuracy of verbal orders.

HRCF PFC 3.3 Medications are stored and administered in accordance with all applicable laws, regulations, and codes and pursuant to each patients' individual medication record developed as part of the hospice plan of care.

HRCF PFC 3.4 The hospice residential care facility arranges for a licensed pharmacist to monitor ordering, safe storage, dispensing, disposal, and record-keeping related to pharmaceutical services and to provide review and consultation regarding each patient's medications in accordance with manufacturers' recommendations (e.g., safe storage, encompassing proper temperature, controlled ventilation, and humidity; as well as attention to expiration dates).

Practice Examples:

- The hospice residential care facility arranges with the patients to self-administer their own medications when policy allows and it is safe for them to do so.
- The hospice residential care facility has a process for securing necessary medications 24 hours a day, 7 days a week.
- Physicians sign, date, and record the time on all verbal orders within the timeframe designated by state standards of practice (no stamped physician signatures are permitted).
- A medication administration record is maintained for each patient and each medication administered by a staff member is documented.
- The hospice residential care facility has emergency medications available to manage pain and other symptoms, and qualified staff has access to these medications 24 hours a day.

Standard:

HRCF PFC 4: Death that occurs in the hospice residential facility is handled with respect and compassion toward the patient and family/caregiver.

HRCF PFC 4.1 Postmortem policies and procedures are in place and include:

- Compassionate care and preparation of the body in accordance with the desires of the patient and family/caregiver;
- Respect for any cultural and/or religious rituals or practices, spiritual traditions, and beliefs relating to the death and subsequent handling of the body and mourning of the family/caregiver;
- Allowance for family/caregiver presence with the patient's body, as desired, and for a reasonable amount of time after the patient's death;
- Provision of spiritual, psychosocial, and/or bereavement care or services as needed or desired by the family/caregiver;
- Provision of the dignified removal of the patient's body; and
- Disposal of all patient medications in accordance with applicable state and federal/state laws.

Practice Examples:

- Specific training, including information regarding respect for cultural and religious beliefs, is provided to the hospice residential facility staff to provide care at the time of a patient death.
- Family/caregivers are afforded privacy with the patient's body as desired.
- Private meditation space is available for family/caregivers' use.
- The removal of the patient's body from the hospice residential facility is handled with privacy, dignity, and respect.
- Policies and procedures permit family/caregiver to remain for reasonable periods of time in the patient's room following death.
- The hospice allows time for facility staff and volunteers to participate in memorial observance of deaths that occurred in the residential facility.

HRCF EBR 1: ETHICAL BEHAVIOR AND CONSUMER RIGHTS (HRCF EBR)

Standard:

EBR 1: Upon admission to the residential care facility, the patient/representative is provided with patient rights as a resident and facility rules and behavior expectations (e.g., smoking policy, privacy for self and other residents, visitor rules, supervision of children visiting, process to leave the facility for short periods).

Practice Example:

- The hospice residential care facility briefs new family members on confidentiality expectations for all patients and families residing within the facility.

HRCF CES 1: CLINICAL EXCELLENCE AND SAFETY (HRCF CES)

Standard:

HRCF CES 1: The hospice residential care facility is designed to provide a homelike environment.

HRCF CES 1.1 The hospice residential care facility decor is homelike in design and function.

HRCF CES 1.2 The hospice residential care facility has physical space and policies and procedures that assure:

- Patient and family/caregiver privacy;
- Visitation privileges that include young children are supervised by persons other than staff;
- Appropriate gathering space provided for privacy; and
- Individual practices of faith are respected.

HRCF CES 1.3 The hospice residential care facility has physical space and equipment that addresses and supports:

- The patient's plan of care and its coordination and continuity;
- Appropriate proximity of the patient to toileting and bathing areas;
- Closet space for security and privacy;
- No more than two (2) beds in any single patient room;
- At least 120 square feet for a single patient room and at least 100 square feet for each patient residing in a double room, or in compliance with state law;
- Devices for summoning staff that can be adapted, as needed, for patient/family/caregiver use;
- A comfortable room temperature for residents throughout the entire year;
- An adequate supply of hot water with plumbing control valves that automatically regulate temperature to avoid the risk of scalds and burns;
- Routine storage and prompt disposal of trash and medical waste; and
- Emergency gas, electric, and water supply.

HRCF CES 1.4 The hospice residential care facility has physical space and a plan that permits appropriate patient access to the outdoors.

HRCF CES 1.5 Telephone access is made available to residents that permit private communication.

HRCF CES 1.6 The hospice residential care facility has ample quality linens available for the appropriate care and comfort of patients. Linens are handled, stored, processed, and transported in compliance with applicable infection control standards, policies, and procedures.

HRCF CES 1.7 The hospice residential care facility has policies and procedures addressing the isolation of patients with infectious diseases and complies with applicable infection control standards, policies, and procedures.

HRCF CES 1.8 The hospice residential care facility has a plan that permits the dignified private removal of bodies.

HRCF CES 1.9 The hospice residential care facility provides an area for patients and family to practice their own spiritual beliefs and practices.

Practice Examples:

- Patient accessible televisions, DVD's, computers/internet access, and radios/CD players are available.
- Private areas are available for the family/caregiver's use following the death of a patient.
- Spaces exist that are designed to accommodate visiting children or other dependents and their needs.
- Patient isolation policies and procedures that encourage as much patient flexibility as possible and preserve patient dignity are in place.
- Housekeeping services maintain a safe clean environment on a daily and as needed basis and are compliant with health and safety rules and regulations.

Standard:

HRCF CES 2: The hospice residential care facility provides services designed to meet the unique nutritional needs of each patient.

HRCF CES 2.1 Meal planning and timing of meals are discussed with patients.

HRCF CES 2.2 Food served is palatable, attractive, and served at the proper temperature.

HRCF CES 2.3 Special dietary restrictions and patient wishes are noted in the patient's plan of care and food and nutritional supplements are provided accordingly.

HRCF CES 2.4 The facility ensures that food is procured, stored, prepared, distributed, and served under sanitary conditions in accordance with applicable laws, rules, and regulations, and in a manner that is appealing to the patient's wishes.

HRCF CES 2.5 Any patient requiring assistance with meal planning and/or feeding receives such assistance by staff, volunteers, family members, or caregivers.

HRCF CES 2.6 A registered dietitian oversees meal planning in accordance with applicable federal, state, and local health and safety laws and any medically prescribed special diets.

HRCF CES 2.7 Food brought in by family members or friends is stored and prepared for the patient in accordance with all applicable laws, rules, and regulations.

Practice Examples:

- Trained volunteers are available during mealtimes to assist patients with feedings as needed and directed.
- Special diets are noted on the patient's plan of care and food is ordered and provided accordingly.
- Food, including between meal snacks or nourishment, is available 24 hours a day, 7 days a week to respond to the patient's reasonable requests and needs, unless limited by dietary restrictions prescribed by a physician.

- Meals are planned with consideration for patient's cultural and religious background and food preferences.
- All food equipment is fixed and mobile, and dishes are kept clean and maintained in good repair and free of breaks, open seams, cracks, or chips.
- Kitchen areas are available that allow for family/caregiver food preparation for the patient.

Standard:

HRCF CES 3: The hospice residential care facility makes reasonable accommodation for family members/caregivers and friends to remain with the patient 24 hours, 7 days a week.

Practice Examples:

- A bathroom and shower are available for family members/caregivers and friends.
- Convertible patient furniture or portable "beds" are available for family members/caregivers and friends.
- A family kitchen area is available for family/caregivers to store and prepare food for a reasonable and safe number of visitors, or family may arrange with facility to pre-order and purchase meals from patient meal suppliers.

Standard:

HRCF CES 4: The hospice residential care facility staff is prepared for the demands of an emergency event that impacts or severely limits the facility's operations.

HRCF CES 4.1 The hospice has a written emergency preparedness plan that is reviewed and updated at least annually and is regularly communicated to staff through orientation and ongoing education. The plan includes:

- A definition of an emergency event and anticipated emergency situations for the facility's location and circumstances;
- A facility-based and community-based risk assessment utilizing an all-hazards approach;
- A practice for "sheltering in place" when advisable instead of evacuation;
- Arrangements for prompt identification and transfer of patients and records to another facility if necessary;
- Arrangements for coordination of community resources;
- Collaboration and coordination with federal, state, tribal, regional, and local emergency management agencies to respond during an emergency event, including the ability to receive other hospice patients during an emergency event; and
- Compliance with all applicable codes, laws, and other regulations.

HRCF CES 4.2 The facility staff demonstrates and evaluates their proficiency in understanding the emergency preparedness plan by routine rehearsal on all shifts. Facility staff must:

- Participate in a community-based mock emergency drill at least annually.
- Conduct a paper-based tabletop exercise at least annually.

HRCF CES 4.3 The emergency preparedness plan is regularly evaluated for appropriateness and revised as necessary.

Practice Examples:

- The facility annually reviews and collaborates with the hospice agency on its written emergency plan.
- Documented transfer arrangements with other facilities are regularly reviewed.
- Evacuation diagrams are posted and visible to all staff, patients, and family members/caregivers.
- Supervision of patients during evacuation or relocation, and contact after relocation to ensure that relocation has been completed as planned, is delineated in the emergency preparedness plan.
- Rehearsals and critiques are conducted semi-annually for the emergency preparedness plan on all shifts.
- The facility has a back-up generator for short-term electrical generation.
- During an imminent or actual emergency event there is a means of contacting the hospice agency administration and local safety agencies such as the fire department, law enforcement, civil defense, and other emergency management authorities. Telephone numbers or other contact methods are accessible to staff and tested at least annually to ensure they are valid and working.

Standard:

HRCF CES 5: The hospice residential care facility meets all federal, state, and local laws, regulations, and codes pertaining to health and safety, especially the latest edition of the National Fire Protection Association's (NFPA) Life Safety Code.

HRCF CES 5.1 The hospice residential care facility has been constructed and/or renovated to comply with applicable laws, regulations, and codes.

HRCF CES 5.2 The hospice residential care facility is sufficiently equipped, maintained, and sanitized to care for admitted patients and to comply with applicable state and federal laws, regulations, and codes.

HRCF CES 5.3 The hospice residential care facility has received any appropriate Centers for Medicare and Medicaid Services (CMS) and/or state written waivers related to the NFPA's Life Safety Code or other safety codes, rules, and regulations.

Practice Examples:

- A mechanism exists for staff to report equipment maintenance needs.
- A preventive maintenance program exists for all building systems such as HVAC, sprinkler, and security systems.
- Facility leadership routinely review safety checks, fire drill performance, and emergency preparedness drills, and debrief after safety/emergency events to identify and plan areas of improvement.
- Announced and unannounced fire/emergency drills are regularly conducted pursuant to local and state minimum guidelines. Fire bell tests are scheduled on a required regular basis.
- Fire extinguishing equipment and sprinkler systems are tested according to local and state guidelines.
- All outdoor and indoor passageways and stairways are kept free of obstruction, including wheelchairs and walkers.
- Nightlights are maintained in hallways and passages to non-private bathrooms.
- Emergency exits are clearly marked, well-lit, and barrier free.

Standard:

HRCF CES 6: The hospice residential care facility is safe, clean, and secure for patients, families/caregivers, volunteers, and employees.

HRCF CES 6.1 The hospice residential care facility has written policies and procedures that are communicated to staff and appropriate for the facility's location that address:

- Security measures;
- Visitor entrance procedures;
- Access to authority figures (e.g., hospice administration, security staff, police/sheriff, fire);
- Inappropriate, unwanted, and harmful behaviors;
- Monitoring of public areas;
- Smoking in the facility and on the grounds of the facility;
- Informing residents and visitors of expectations related to safety measures and expected behaviors; and
- Infection surveillance and control.

HRCF CES 6.2 Patient care areas in the hospice residential care facility meet Life Safety Codes and local fire and safety standards and are located at or above grade level.

HRCF CES 6.3 The hospice residential care facility maintains a sanitary environment and has general preventive infection control practices in place, as well as the use of isolation when needed.

HRCF CES 6.4 The hospice residential care facility has written policies and procedures to address the cleanliness and safety of the facility.

HRCF CES 6.5 The hospice residential care facility has a process to report, document, and evaluate safety and security incidents for corrective action.

HRCF CES 6.6 The hospice must determine the appropriate licensure category for the hospice residential care facility and obtain a license from the appropriate local or state authority. The license shall be posted in a prominent location in the facility accessible to public view.

Practice Examples:

- Safety behavior expectations of residents and visitors are provided, in writing, upon facility admission and are appropriately posted (e.g., smoking, cooking, weapons, access when doors are locked, hand washing signs in restrooms).
- Electronic alarm and voice or video systems exist to monitor the grounds and entrances.
- Visitor identification requirements exist and are enforced.
- Electronic devices (e.g., panic buttons linked to 911) exist to summon authorities.
- Staff education programs are provided regularly and as needed to enforce and highlight security and safety issues.
- Policies and procedures are available for dealing with patient, family/caregiver, or visitor behavior that is unacceptable and/or impaired.
- All staff members receive and are compliant with always wearing identification badges while working at the facility.

Standard:

HRCF CES 7: The hospice has policies and procedures regarding the use of physical and chemical restraints. All patients have the right to be free from seclusion or restraint, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Seclusion or restraint 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.

HRCF CES 7.1 All patients have the right to be free from seclusion or restraint, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

HRCF CES 7.2 Seclusion or restraint 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.

HRCF CES 7.3 All patient care staff working in the hospice residential care facility must have training and demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in seclusion or restraints.

HRCF CES 7.4 Hospices must report deaths associated with the use of seclusion or restraints in accordance with CMS, state, and federal regulations.

HRCF CES 7.5 Hospice residential facility staff members are trained in the use of first aid techniques and certification in the use of cardiopulmonary resuscitation (CPR), including required periodic recertification if the facility is not designated as "restraint and seclusion free."

HRCF CES 7.6 If the residential facility is restraint and seclusion free, the facility must have a policy which includes alternative care provisions to maintain patient, staff, and other's safety.

Practice Examples:

- Hospice has an orientation and ongoing training program related to physical and chemical restraints including assessments, frequency of re-assessments, medical orders, and discontinuation.
- Hospice has a policy addressing alternative treatments or settings to manage patients that are violent or have self-destructive behavior.
- Hospice has a policy for utilizing sitters or companions when safe and appropriate as a first line alternative to restraints.

HRCF IA 1: INCLUSION AND ACCESS (HRCF IA)

Standard:

HRCF IA 1: Access to hospice residential care is made available to all hospice patients who need residential care that cannot be provided in another setting and who meet the general admission criteria for admission to a hospice program.

HRCF IA 1.1 The hospice patient/representative has a right to participate in the decision-making process regarding where care is to be delivered and to choose their attending physician.

HRCF IA 1.2 Access to residential care allows for options other than the hospice residential care facility.

Practice Examples:

- The hospice utilizes written criteria for admission to and continued stay in its hospice residential care facility that does not distinguish between patients based on criteria other than clinical or social necessity.
- The hospice demonstrates consideration of the patient's desire to remain in their choice of home in lieu of admission to the hospice residential facility.
- The hospice does not limit residential options for hospice care to its own hospice residential care facility and does not discharge from hospice services patients requesting the use of other residential facilities within the service area.
- The hospice allows patient choice in attending physician when admitted to the hospice residential care facility.
- The hospice admission criteria and plan of care for the patient consider the individual needs of the patient including socialization and recreational needs and the most appropriate setting for meeting those needs.
- The hospice residential care facility updates new family members/caregivers about confidentiality expectations and behaviors for all patients and families to assist in the best care for their loved ones.
- The hospice has written criteria for selection of patients for admission to the hospice residential care facility when it experiences a waiting list and adheres to the defined process.
- The hospice has clear criteria and clearly explains those criteria to the patient and family/caregiver related to a patient's ability to pay any applicable self-pay portions of a hospice residential facility stay.
- The hospice can demonstrate an ability to provide financial assistance to patients unable to pay self-pay portions of a hospice residential care facility stay.
- The hospice offers written information and community education regarding admission policies and criteria for the hospice residential care facility.
- Patient information materials available for the hospice residential care facility specifically address payment expectations for self-pay portions of charges and the qualifications for financial assistance.

ORGANIZATIONAL EXCELLENCE (HRCF OE)

Standard:

No additional standards apply to organizational excellence in a hospice residential care facility.

WORKFORCE EXCELLENCE (HRCF WE)

Standard:

No additional standards apply to workforce excellence in a hospice residential care facility.

Practice Examples:

- Prospective staff members of the hospice residential care facility are offered an opportunity to speak with a staff member from their discipline to discuss job role, responsibilities, day-to-day activity, and expectations before hire.
- An orientation program for hospice residential care facility staff and volunteers includes safety procedures such as patient and visitor behaviors, building security, infection control, inclement weather reactions, and evacuation decisions.
- Staff members with responsibilities in multiple work site locations are specifically oriented to similarities and differences in care of patients residing in the hospice residential care facility.
- Hospice residential care facility volunteers are fully oriented to the hospice residential care facility in addition to standard volunteer training activities.

COMPLIANCE WITH LAWS AND REGULATIONS (HRCF CLR)

Standard:

No additional standards apply to compliance with laws and regulations in a hospice residential care facility.

Practice Example:

- A greeter for visitors (employee or volunteer) complies with HIPAA rules and is informed of appropriate and limited patient information.

STEWARDSHIP AND ACCOUNTABILITY (HRCF SA)

Standard:

No additional standards apply to stewardship and accountability in a hospice residential care facility.

Practice Examples:

- An organizational chart exists that clearly designates responsibility and accountability for care and maintenance of the hospice residential care facility and the facility's accountability relationship with the hospice agency.

- The governing body's minutes of the organization indicate regular routine reporting and evaluation of the operation of the hospice residential care facility.
- Minutes of appropriate planning groups consider the number of hospice residential care facility beds that may be appropriate for a particular community as part of the licensure process.

PERFORMANCE MEASUREMENT (HRCF PM)

Standard:

No additional standards apply to performance measurement in a hospice residential care facility.

Practice Examples:

- The hospice's annual performance improvement plan includes specific activities that address the improvement needs of the hospice residential care facility.
- The hospice residential care facility staff participates in the hospice's overall Quality Assurance and Performance Improvement (QAPI) program.
- The hospice plans opportunities for residential care facility patients and families to give feedback for improving the facility's care.



Patient and Family-Centered
Care (PFC)

Patient and Family-Centered Care (PFC)

| Patient and Family-Centered Care (PFC) | |
|--|--|
| Standard | 2022 |
| Principle | Revised |
| PFC 4.1 | Added #2; Text change; Renumbered |
| PFC 4.2 | Deleted #1 & 2. Renumbered |
| PFC 4.5 | Eliminated |
| Practice Examples | Deleted example #2; Example #4 text addition. |
| PFC 5.2 | Text addition |
| PFC 5.3 | Text addition |
| Practice Examples | Example #3 deleted |
| PFC 6.1 | Revised |
| PFC 6.3 | Revised; Text addition |
| PFC 6.4 | Text addition |
| Practice Examples | Example #1 deleted; Example #2 text removed. |
| PFC 7.1 | Deleted PFC 7.1; Renumbered previously 7.2; Revised #1 |
| PFC 7.2 | Eliminated |
| Practice Examples | Example #2 revised |
| PFC 9.2 | Revised |
| PFC 9.3 | Renumbered; Previously PFC 9.4 |
| PFC 9.4 | Renumbered; Previously PFC 9.3 |
| Practice Examples | Example #3 revised |
| PFC 10.1 | Revised |
| PFC 10.2 | Revised |
| PFC 10.3 | Text addition |
| PFC 10.5 | New sub standard |
| Practice Examples | Example #2 text added |

| Patient and Family-Centered Care (PFC) | |
|---|---|
| Standard | 2022 |
| Principle | Revised |
| PFC 11.5 | New sub standard |
| Practice Examples | Example #4 deleted; Example number 7 revised |
| PFC 12.1 | Deleted & renumbered; Previously PFC 12.3 |
| PFC 12.3 | Previously PFC 12.4 |
| PFC 12.4 | Eliminated |
| Practice Examples | Example #5 added |
| PFC 13.1 | Previously PFC 13.3 |
| PFC 13.2 | Previously PFC 13.1; Revised |
| PFC 13.3 | Previously PFC 13.2 |
| PFC 13.5 | New Sub-standard |
| Practice Examples | Example #5 text added |
| PFC 14.2 | Revised |
| Practice Examples | Example #3 text added |
| PFC 15 | Text added |
| PFC 15.3 | Revised |
| PFC 15.4 | Revised |
| PFC 15.5 | Deleted |
| PFC 15.6 | Deleted |
| Practice Examples | Example #3 text added |
| PFC 16.2 | Text added |
| Practice Examples | Example #1 added; example #5 revised (Previously Example #4) |

| Patient and Family-Centered Care (PFC) | |
|---|--|
| Standard | 2022 |
| Principle | Revised |
| PFC 17.2 | Deleted; renumbered; Previously PFC 17.3 |
| PFC 17.3 | Previously PFC 17.4 |
| PFC 17.4 | Previously PFC 17.5 |
| PFC 17.5 | Eliminated |
| Practice Examples | Example #4 text added |
| Practice Examples | Example #2 text added |



Ethical Behavior and
Consumer Rights (EBR)

Ethical Behavior and Consumer Rights (EBR)

| Ethical Behavior and Consumer Rights (EBR) | |
|--|---|
| Standard | 2022 |
| Principle | Revised - Removed reference to NHPCO's Guide to Organizational Ethics in Hospice Care (2016) . Added – Information about NHPCO's CaringInfo with a link to the webpage. |
| EBR 1.11 | New standard |
| EBR 1 - Practice example | Added - United States Census information or the Office of Civil Rights (OCR) list of the top 15 languages spoken by individuals with Limited English Proficiency (LEG) in each state, the District of Columbia, and each U.S. Territory – PDF |
| EBR 1.2 | Text change |
| EBR 1.4 | Text change |
| EBR 1.11 | New standard – Previous practice example |
| EBR 1 | #6 – new practice example |
| EBR 2.1 | Text change |
| EBR 3.2 | Added "patients and their family/caregivers" |
| EBR 3 - Practice example | #1 - deleted |
| EBR 4 | Added "patient's and family/caregiver's" at the beginning of the bulleted list |
| EBR 4 – practice examples | #9, 10 – new examples Deleted duplicative bullet re: addressing the patient by their preferred name |
| EBR 4.2 | #4 in list – text change |
| EBR 6.4 | Text change (e.g., added "comprehensive ethics policy that addresses key topics such as on composition and responsibilities of an...") |
| EBR 9.2 | Added a resource |



Clinical Excellence and Safety (CES)

Clinical Excellence and Safety (CES)

| Clinical Excellence and Safety (CES) | |
|--------------------------------------|---|
| Standard | 2022 Changes |
| CES 1 – Practice examples | Examples #4, #6, #10 – text change |
| CES 4.1 | Number change; previously 4.2 |
| CES 4.2 | Number change; previously 4.3; Text change |
| CES 4.3 | New standard |
| CES 4.5 | Text change to list item #15 |
| CES 4.12 | New standard |
| CES 4.13 | Number change; previously CES 4.12 |
| CES 4.14 | New standard |
| CES 4.15 | Number change; previously CES 4.13 |
| CES 4.16 | New standard |
| CES 4.17 | Number change; previously CES 4.15 |
| CES 4.18 | New standard |
| CES 7 – Practice Examples | #6 – new |
| CES 10.2 | #2-3 – new in list |
| CES 13 – Practice example | Practice example #4 eliminated and moved to pediatric standards |
| CES 13.1 | #5 in list – text change; #9-10 in list – new Changed hyperlink and descriptor to CDC PPE Burn Rate Calculator (as opposed to the link to Ebola-related PPE) |
| CES 14 – Practice examples | #5-7 new examples |
| CES 14.3 | New standard Added hyperlink to CDC's COVID-19 primary vaccination schedule |



Inclusion & Access (IA)

Inclusion & Access (IA)

| Inclusion & Access (IA) | |
|---------------------------------|--|
| Standard | 2022 Changes |
| IA 1 – Practice examples | Text change to #4– additional text |
| IA 1.1 | Text change – additional text |
| IA 1.4 | Text change – additional text |
| IA 2.1 | Text change – additional text |
| IA 2.2 | Text change – additional text |
| IA 2.3 | Resource added |
| IA 2.5 | Text change – additional text; Resource added |
| IA 2 – Practice examples | Text change to #2-3; added #4 |
| IA 3 – Practice examples | Text change #1 – additional text; resource added Text change #6 – additional text |
| IA 4- Practice examples | Text change #4 |



Stewardship & Accountability (SA)

Stewardship & Accountability (SA)

| Stewardship & Accountability (SA) | |
|-----------------------------------|---|
| Standard | 2022 Changes |
| SA 1 – Practice examples | New example - #6 Reworded last bullet re: prioritization of diversity and inclusion in board composition and reflecting community served |
| SA 5 – Practice examples | Webpage links - #4; webpage link added - #6 |
| SA 8.2 | List item changes: #2, #4 – new; #7 – text change and resource added) |
| SA 8.3 | Text change |
| SA 8.3 – Practice example | New examples - #2-3 |



Appendix III: Hospice Residential
Care Facility (HRCF)

Appendix III: Hospice Residential Care Facility (HRCF)

| Appendix III: Hospice Residential Care Facility (HRCF) | |
|--|--|
| Standard | 2022 Changes |
| HRCF PFC 1 – Practice examples | <p>2018 eliminated examples:</p> <ul style="list-style-type: none"> ■ Staff assigned to the hospice residential care facility has received training in hospice care including pain and symptom management. ■ Staffing schedules demonstrate availability of a registered nurse twenty-four (24) hours a day, seven (7) days a week. ■ There is clinical documentation that supports each patient accepted for admission has a life expectancy of six months or less (if the terminal condition follows its normal course) and the plan of care can safely be managed at the level of care provided at the residence. ■ Policies and procedures are in place for the assessment, documentation, and communication of the reasons for admission to the residence. ■ A procedure is followed for transfer of patients to an inpatient setting when required. ■ The hospice IDT conducts case conferences at the hospice residential care facility with the patient and family/caregiver invited to explore care plan options as appropriate. ■ The hospice residential care facility hospice interdisciplinary team members (including hospice aides and volunteers) participate in hospice interdisciplinary team meetings and provide input for the care planning process on an ongoing basis. <p>#1 – Text change for clarification</p> |
| HRCF PFC 2 – Practice examples | <p>2018 eliminated example:</p> <ul style="list-style-type: none"> ■ A process exists to provide spiritual/psychosocial/bereavement support to the hospice residential care facility staff as needed in promoting self-care. |
| HRCF PFC 4- Practice examples | <ul style="list-style-type: none"> ■ Added "caregiver" after "family" |
| HRCF EBR 1 – Practice examples | <p>2018 eliminated example:</p> <ul style="list-style-type: none"> ■ The hospice has policies and procedures for approval of icons, shrines, etc. that patients and families may wish to use within the hospice residential care facility. |
| HRCF CES 1 – Practice examples | <ul style="list-style-type: none"> ■ Added "or other dependents" after "children" |
| HRCF CES 2 – Practice examples | <ul style="list-style-type: none"> ■ Changed "food habits" to "food preferences" |

Appendix III: Hospice Residential Care Facility (HRCF)

| Standard | 2022 Changes |
|---------------------------------------|--|
| HRCF CES 6 – Practice examples | <p>2018 eliminated examples:</p> <ul style="list-style-type: none"> ■ Criminal background clearance checks are performed at minimum according to state guidelines prior to employees and volunteers having contact with patients. Incidents are regularly reported and reviewed, and systems are regularly assessed for needed change. ■ Grab bars are maintained for each toilet, bathtub, and shower used by patients. ■ Non-skid mats or strips are used in all bathtubs and showers. ■ Disinfectants, cleaning solutions, poisons, firearms, and other items that could pose a danger if readily available to residents are stored where inaccessible to patients. ■ Material Safety Data Sheets (MSDS) online or hard copy reports are accessible to staff. ■ Infection control methods are used including personal protective equipment (PPE), disinfecting supplies and protocols, alerts for specific precautions for staff and visitors, and isolation techniques. ■ Added "unwanted, and harmful" after "inappropriate" (re: behaviors). <p>Text changes made to #3-4 for clarification</p> |
| HRCF IA 1 – Practice examples | <p>2018 eliminated example:</p> <ul style="list-style-type: none"> ■ A needs assessment is conducted as part of the initial licensure process to identify support for a hospice residential care facility and the appropriate numbers of beds to be allocated to a facility. |
| HRCF WE – Practice examples | <p>2018 eliminated examples:</p> <ul style="list-style-type: none"> ■ Policies and procedures exist and are adhered to when hospice staff members elect to not participate in a patient's or family/caregiver's request for withdrawal or continuation of life sustaining procedures. ■ Hospice aides assigned to the hospice residential care facility receive specific primary caregiver education such as patient repositioning, transfers, feeding, and reporting patient needs and changes to the RN or medical provider. ■ Hospice aides are fully oriented to all required skills and are observed providing specific tasks or skills with patients prior to independent practice in the hospice residential care facility. |
| HRCF SA – Practice examples | <p>2018 eliminated example:</p> <ul style="list-style-type: none"> ■ The hospice has appropriately reviewed and approved policies guiding admission, continued stay, transfers, discharges from service, and care provided in the hospice residential care facility. |



NHPCO's Hospice Standards of
Practice Glossary and Acronyms

NHPCO's Hospice Standards of Practice Glossary and Acronyms

| NHPCO's Hospice Standards of Practice Glossary and Acronyms | |
|---|--|
| Term | Definition |
| Accreditation¹ | An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures, and performance by an external organization ("accrediting body") to ensure that it is meeting predetermined criteria. It usually involves both on- and off-site surveys. |
| Family | <p>For the purpose of these standards, "family" is what the patient defines as family.</p> <p>The CMS hospice definition of "Family" includes, but is not limited to, an individual's "spouse;" and "relative" when used as a noun, includes, but is not limited to, an individual's "spouse." Furthermore, except where CMS regulations explicitly require an interpretation in accordance with State law, wherever the text of a regulation or associated guidance uses the above terms or includes a reference to a patient's "representative," "surrogate," "support person," "next-of-kin," or similar term in such a manner as would normally implicitly or explicitly include a spouse, the terms are to be interpreted consistent with the guidance above.²</p> <p>A hospice is expected to recognize all lawful marriages and spouses for purposes of compliance with the Conditions of Participation, regardless of any laws to the contrary of the state or locality or other jurisdiction where the hospice is located or where the spouse lives.</p> |
| Attending physician³ | Doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs that function or action; or a nurse practitioner who meets the necessary training, education, and experience requirements. Is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care. |
| Bereavement counseling⁴ | Emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment. |
| Cap period⁵ | The twelve-month period ending October 31 used in the application of the cap on overall hospice reimbursement specified in §418.309. |
| Clinical note⁶ | A notation of a contact with the patient and/or the family that is written and dated by any person providing services and that describes signs and symptoms, treatments and medications administered, including the patient's reaction and/or response, and any changes in physical, emotional, psychosocial or spiritual condition during a given period of time. |

| NHPCO's Hospice Standards of Practice Glossary and Acronyms | |
|---|--|
| Term | Definition |
| CDC | Center for Disease Control and Prevention |
| CMS⁷ | The Centers for Medicare & Medicaid Services, CMS, is part of the Department of Health and Human Services (HHS). The CMS oversees programs including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the state and federal health insurance marketplaces. CMS collects and analyzes data, produces research reports, and works to eliminate instances of fraud and abuse within the healthcare system. |
| Comprehensive assessment⁸ | A thorough evaluation of the patient's physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions. This includes a thorough evaluation of the caregiver's and family's willingness and capability to care for the patient. |
| Cultural (and linguistic) competence⁹ | A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. |
| Dietary counseling¹⁰ | Education and interventions provided to the patient and family regarding appropriate nutritional intake as the patient's condition progresses. Dietary counseling is provided by qualified individuals, which may include a registered nurse, dietitian, or nutritionist, when identified in the patient's plan of care. |
| Employee¹¹ | 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; or (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; or (3) is a volunteer under the jurisdiction of the hospice. |
| HHS | (Department of) Health & Human Services (also DHHS) |
| HETS¹² | The HIPAA (Health Insurance Portability and Accountability Act) Eligibility Transaction System (HETS) allows one to check Medicare beneficiary eligibility data in real-time. Hospices use HETS to prepare accurate Medicare claims, determine beneficiary liability, or check eligibility for specific services. |
| Hospice¹³ | A public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care. |
| Hospice care¹⁴ | A comprehensive set of services described in Section 1861(dd)(1) of the Act, identified and coordinated by an interdisciplinary group (IDG) to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care. |
| Implicit bias¹⁵ | A bias or prejudice that is present but not consciously held or recognized. |

| NHPCO's Hospice Standards of Practice Glossary and Acronyms | |
|---|---|
| Term | Definition |
| Initial assessment ¹⁶ | An evaluation of the patient's physical, psychosocial and emotional status related to the terminal illness and related conditions to determine the patient's immediate care and support needs. |
| Licensed professional ¹⁷ | A person licensed to provide patient care services by the State in which services are delivered. |
| MAC | Medicare Administrative Contractor |
| Microaggression ¹⁸ | A comment or action that subtly and often unconsciously or unintentionally expresses a prejudiced attitude toward a member of a marginalized group (such as a racial minority). |
| Multiple location ¹⁹ | A Medicare-approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice issued the certification number. A multiple location must meet all of the conditions of participation applicable to hospices. |
| OIG | Office of the Inspector General |
| OCR | Office for Civil Rights |
| Palliative care ²⁰ | Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs, and facilitates patient autonomy, access to information, and choice. |
| Physician ²¹ | An individual who meets the qualifications and conditions as defined in Section 1861(r) of the Act and implemented at §410.20 of this chapter. |
| Physician designee ²² | A Doctor of Medicine or Osteopathic Medicine designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available. |
| Representative ²³ | An individual who has the authority under State law (whether by statute or pursuant to an appointment by the courts of the State) to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill patient who is mentally or physically incapacitated. This may include a legal guardian. |
| Restraint ²⁴ | (1) 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 (2) 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. |

NHPCO's Hospice Standards of Practice Glossary and Acronyms

| Term | Definition |
|-------------------------------------|---|
| Seclusion ²⁵ | The involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving. |
| Terminally ill ²⁶ | The individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. |

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