HOSPICE REGULATORY GUIDE

Comparison of WI Administrative Code and Federal Conditions of Participation

NOTE:

- **The sequence of Wisconsin Administrative Code DHS 131 is in chronological order as outlined. The Federal Conditions of Participation regulations under 42 CFR 418 for Hospice Agencies may not be in order sequence as they mirror their corresponding regulation.**
- ***Not included in this document are*: DHS 131, Subchapter 5: Physical Environment; Please see: F00382 https://dhsworkweb.wisconsin.gov/forms/f00382a.docx**
- **418.110 Hospices that Provide In-Patient Care, directly; 42 CFR 418.108 Short-term In-Patient Care; and 418.112 Hospices that provide hospice care to residents of SNF/NF or ICF/IID (some related tags are cross-referenced under Contracted Services)**
- **42 CFR 418.116 Compliance with Laws and Regulation Related to Health and Safety of Patients.**

P Tag	STATE RULE – Chapter DHS 131 * = Agency Policy Required + = Additional Documentation Required	STATE Interpretive Guidelines (G) Surveyor Procedures (P)	L Tag	FEDERAL Conditions of Participation Requirement
	§DHS 131.14(1)(b) A Hospice program may have more than one office or facility. Multiple units do not need to be separately licensed if the hospice is able to demonstrate supervision and administration from the central office. DHS 131.14(2)(2) Application. (a) Application for a license to operate a hospice shall be made in writing on a form provided by the department. (b) The completed application shall contain all of the following information: 1. The name and address of the applicant. 2. The location of the hospice. 3. Identification of the person or persons administratively responsible for the program, and the affiliation, if any, of the person or persons with a licensed home health agency, hospital, nursing home or other health care facility.		L656 L657 L658	§418.100(f) Standard: Hospice multiple locations If a hospice operates multiple locations, it must meet the following requirements: (1) Medicare approval. (i) All hospice multiple locations must be approved by Medicare before providing hospice care and services to Medicare patients. §418.100(f)(1)(ii) The multiple location must be part of the hospice and must share administration, supervision, and services with the hospice issued the certification number. §418.100(f)(1)(iii) The lines of authority and professional and administrative control must be clearly delineated in the hospice's organizational structure and in practice and must be traced to the location which was issued the certification number.

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	4. The proposed geographic area the hospice will serve. 5. A listing of those hospice services provided directly by the hospice, and those hospice services provided through a contractual agreement. 6. A list of those providers under contract with the hospice to provide hospice services. 7. Evidence to establish that the applicant has sufficient resources to permit operation of the hospice for a period of at least 90 days. 8. Any additional information specified by the department as necessary to determine that the entity detailed in the application is a hospice and that the applicant is and is fit and qualified to operate it. (c) The applicant shall submit the application form to the department accompanied by the applicable fee established under s. 50.93 (1) (c), Stats.		L659 L660 L661	§418.100(f)(1)(i)(iv) The determination that a multiple location does or does not meet the definition of a multiple location, as set forth in this part, is an initial determination, as set forth in §498.3. §418.100(f)(2) The hospice must continually monitor and manage all services provided at all of its locations to ensure that services are delivered in a safe and effective manner and to ensure that each patient and family receives the necessary care and services outlined in the plan of care, in accordance with the requirements of this subpart and subparts A and C of this section. §418.100(g) Standard: Training (1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact
	Note: To obtain an application form for a license, write the Bureau of Technology, Licensing and Education, Division of Quality Assurance, Department of Health Services, P.O. Box 2969, Madison, WI 53701-2969 or telephone (608) 266-2702. The completed application form should be sent to the same office.		L662 L663	§418.100(g)(2) - A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties. §418.100(g)(3) A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months.

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	§ DHS 131.17 Admission. **(1)** PROGRAM DESCRIPTION. A hospice shall have a written description of its program that clearly describes the general patient and family needs that can be met by the hospice, and that includes written admission policies that includes all of the following: (a) Clearly define the philosophy of the program. (b) (b) Limit admission to individuals with terminal illness as defined under § DHS 131.13(24). (c) (c) Clearly define the hospice's limits in providing services and the settings for service provision. (d) Ensure protection of patient rights. (e) Provide clear information about services available for the prospective patient and his or her representatives, if any. (f) Allow an individual to receive hospice services whether or not the individual has executed an advance directive.	G: Hospice shall have a clear, written program description. Such a written program description needs to be provided to the prospective patient and acknowledged in writing prior to initiating services to the patient and family. P: Survey staff to review program description and information provided to the patient.		
	(2) PROGRAM EXPLANATION. (a) A hospice employee shall inform the person and his or her representative, if any, of admission policies under sub. (1).	G: The hospice employee designated by the care coordinator shall explain the program to the prospective patient and family prior to the initiation of clinical assessment. P: Survey staff to conduct home visits and review a sample of patient records to determine whether the information defined in 131.17(1) was provided to the relevant individuals at the time of assessment, including review of Admission Policy.		

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	(3) INITIAL DETERMINATION. (a) The hospice employee shall, based on the needs described by the person seeking admission or that person's representative, if any, or both, make an initial determination as to whether or not the hospice is generally able to meet those needs.			
	(b) If the hospice employee determines that the hospice does not have the general capability to provide the needed services, the hospice may not admit the person but rather shall suggest to the referring source alternative programs that may meet the described needs.			
2060	**(4)** PATIENT ACKNOWLEDGEMENT AND HOSPICE ACCEPTANCE. The person seeking admission to the hospice shall be recognized as being admitted after:			
2060	(a) Completion of the assessment under sub. (3).			
2060	(b) Completion of a service agreement in which:			
2060	1. The person or the person's representative, if any, acknowledges, in writing, that he or she has been informed about admission policies and services.			
2060	2. The hospice agrees to provide care for the person.			
2060	3. The person or the person's representative, if any, authorizes services in writing.			
2065	**(5)** PROHIBITION. Any person determined not to have a terminal illness as defined under § DHS 131.13(24) may not be admitted to the hospice.			

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2070	**§ DHS 131.18 Discharge.** **(1)** OBLIGATION. Once a hospice has admitted a patient to the program, and the patient or the patient's representative, if any, has signed the acknowledgement and authorization for services under § DHS 131.17(4)(b), the hospice is obligated to provide care to that patient.	G: Refer to § DHS 131.17(4), Patient Acknowledgment, and hospice acceptance. P: Interview administrator to ascertain agency discharge criteria and number of patients discharged during a recent time period.		
2110	**(2)** WRITTEN POLICY. The hospice shall have a written policy that details the manner in which the hospice is able to end its obligation to a patient. This policy shall be provided to the patient or patient's representative, if any as part of the acknowledgement and authorization process at the time of the patient's admission. The policy shall include all of the following as a basis for discharging a patient:	P: Review written policy and verify that it has been provided to the patient or patient's representative.		
2110	(a) The hospice may discharge a patient:			
2110	1. Upon the request or with the informed consent of the patient or the patient's representative.			
2110	2. If the patient elects care other than hospice care at any time.	G: Hospice shall discharge a patient from the program if the patient chooses to seek care for their terminal illness from a program not related to the hospice program.		
2110	3. If the patient elects active treatment, inconsistent with the role of palliative hospice care.			
2110	4. If the patient moves beyond the geographical area served by the hospice.			

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2110	5. If the patient requests services in a setting that exceeds the limitations of the hospice's authority.			
2110	6. For nonpayment of charges, following reasonable opportunity to pay any deficiency.			
2110	7. For the patient's safety and welfare or the safety and welfare of others, if the hospice determines that the behavior of the patient or other persons in the patient home is disruptive, abusive, or uncooperative the extent the delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.	G: This specific cause does NOT require a 14-day notice. DHS 131.18 (3) Notice.		
2110	8. If the hospice determines that the patient is no longer terminally ill.			
2110	(b) The hospice shall do all of the following before it seeks to discharge a patient whose behavior or the behavior of other persons in the patient's home, is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.			
2110	1. Advise the patient that a discharge for cause is being considered.			
2110	2. Make a serious effort to resolve the problem or problems presented by the patient's behavior or situation.			
2110	3. Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services.			
2110	4. Document the matter and enter this documentation into the patient's clinical record.			

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2140	**(3)** NOTICE. When a patient is being discharged for a reason given in sub. (2)(a) 1., 2., 3., 4., 5., 7., or 8. the hospice shall give written notice of the discharge to the patient or patient's representative, if any, family representative and attending physician. (b) When the patient is being discharged for reason given in sub. (2)(a)6., the hospice shall give written notice at least 14 days prior to the date of discharge, with a proposed date for a pre-discharge planning. The written notice shall be given to the patient or patient's representative, if any, a family representative and attending physician.	G: Hospice discharge policy shall detail within written procedures the manner in which the patient is to be discharged from the hospice program. This procedure shall include the serving of written notice to the patient/patient or family representative at least 14 days prior to the date of discharge, along with a proposed date for a pre-discharge planning meeting. P: Survey staff to review a sample of discharge patient records.		
2145	**(4)** PLANNING. The hospice shall conduct the pre-discharge planning with the patient or the patient's representative and review the need for discharge, assess the effect of discharge on the patient, discuss alternative placements and develop a comprehensive discharge plan.			
2165	**DHS 131.19 Patient rights.** **(1)** GENERAL INFORMATION. A hospice shall provide each patient and patient's representative, if any, with a written statement of the rights of patients before services are provided and shall fully inform each patient and patient's representative, if any, of all of the following:	G: Hospice shall have a procedure to provide patient rights and information in written form to the prospective patient/representative. P: Survey staff to ascertain whether all rights under § DHS 131.19 were provided in written form to the relevant individuals prior to the initiation of services by the hospice program. Method: Review statement of patient rights.	**L502**	**418.52 (a) Standard: Notice of rights and responsibilities**. (1) During the initial assessment visit in advance of furnishing care the hospice must provide the patient or representative with verbal (meaning spoken) and written notice of the patient's rights and responsibilities in a language and manner that the patient understands.
2165	(a) Those patient rights and all hospice rules and regulations governing patient responsibilities, which shall be evidenced by written acknowledgement provided by the patient, if possible, or the patient's representative, if any, prior to receipt of services.	P: Survey staff to review selected patient records for written acknowledgment by relevant individual, prior to initiation of services by the hospice program.	**L504**	(3) The hospice must obtain the patient's or representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.
2165	(b) The right to prepare an advance directive.	G: Hospice must maintain policies and procedures concerning Advanced Directives with respect to all adult individuals receiving medical care by or through the provider and are required to:418.52(a)(2) 1-6. P: Survey staff to review policies and procedures. Select patient records for which written information was provided on Admission.	**L503**	(2) The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law.

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2165	(c) The right to be informed of any significant change in the patient's needs or status.			
2165	(d) The hospice's criteria for discharging the individual from the program.	G: Hospice to provide patients with written statement of criteria for discharge from the program. P: Survey staff to review selected sample of patient records. Sample should include both active and discharged records. Relate findings to § DHS 131.18 Discharge.		
	(2) RIGHTS OF PATIENTS. In addition to rights to the information under sub. (1), each patient shall have all of the following rights:	P: Survey staff will review selected sample of patient records and conduct home visits for outcome of process. In addition, selected patients or spokespersons may be interviewed (with permission granted) as a means of ascertaining that patient has had involvement in the development in his/her Plan of Care.		
2170	(a) To receive effective pain management and symptom control from the hospice for conditions related to the terminal illness.	G: Hospice should have methods in place to assure that the patient's pain, and all other distressing symptoms are controlled effectively 24 hrs/day, 7 days/week in all settings and wherever the patient resides.	**L512**	**418.52 (c) Standard: Rights of the patient** The patient has a right to the following: (1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness.
2175	(b) To participate in planning care and in planning changes in care.		**L513**	(2) Be involved in developing his or her hospice plan of care.
2180	(c) To select or refuse care or treatment.		**L514**	(3) Refuse care or treatment
2185	(d) To choose his or her attending physician.		**L515**	(4) Choose his or her attending physician
2190	(e) To confidential treatment of personal and clinical record information and to approve or refuse release of information to any individual outside the hospice, except in the case of transfer to another health care facility, or as required by law or third party payment contract.	G: Safeguarding the content, including paper records and/or electronically stored information from unauthorized disclosure without the specific informed consent of the patient or legal representative. P: Review policies and procedures if warranted.	**L516**	(5) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.
2195	(f) To request and receive an exact copy of one's clinical record.			

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2200	(g) To be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property.	G: States commonly have mandatory reporting requirements for providers, suppliers, and individuals making them legally responsible to report suspicions of abuse and neglect to appropriate State authorities. Reference: WI Administrative Code, Chapter DHS 13.05 P: Survey staff with review of any reported Abused and review policy and procedures.	**L517**	(6) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property.
2205	(h) To be free from restraints and seclusion except as authorized in writing by the attending physician to provide palliative care for a specified and limited period of time and documented in the plan of care.	G: With respect to § DHS 131.19(2)(h), the hospice needs to assure the relevant individuals that the use of chemical and physical restraints shall not occur. The patient has the right to refuse services. [See § DHS 131.19(2)(c).] P: Survey staff will review a sample of patient records and conduct home visits to ensure that, if chemical or physical restraints are used.		
2210	(i) To be treated with courtesy, respect and full recognition of the patient's dignity and individuality and to choose physical and emotional privacy in treatment, living arrangements and the care of personal needs.	P: Survey staff will review a sample of patient records and conduct home visits to ensure intent of § 131.19(2)(i)(j)(k).	**L505**	**418.52 (b) Standard: Exercise of rights and respect for property and person** (1) The patient has the right: (i) To exercise his or her rights as a patient of the hospice; (ii) To have his or her property and person treated with respect;
2215	(j) To privately communicate with others without restrictions			
2220	(k) To receive visitors at any hour, including small children, and to refuse visitors.			

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2225	(l) To be informed prior to admission of the types of services available from hospice, including contracted services and specialized services for unique patient groups such as children.	G: Hospice assures that the procedure developed informs the relevant individuals in writing about the types of services available, including the fact that contracted services may be provided through the hospice program. P: Same as above. Survey staff to review selected patient records for evidence that relevant individuals were informed of the types of services available from the hospice.	**L518** **L519**	(7) Receive information about the services covered under the hospice benefit. (8) Receive information about the scope of services that the hospice will provide and specific limitations on those services.
2230	(m) To be informed of those items and services that the hospice offers and for which the resident may be charged, and the amount of charges for those services.	G: Hospice to provide service agreement that informs patient of services and charges signed by the patient.		
2235	**(3)** PATIENT COMPLAINT PROCEDURE. Each patient shall have the right, on his or her own behalf or through others, to do all of the following:			
2235	(a) Express a complaint to hospice employees, without fear of reprisal, about the care and services provided and to have the hospice investigate the complaint in accordance with an established complaint procedure. The hospice shall document both the existence of the complaint and the resolution of the complaint.	G: Hospice shall develop a procedure for patient complaints. The patient needs to be informed of the right to express a complaint. Hospice needs to have a complaint procedure and investigate complaints according to that procedure. Hospice shall document both the complaint and the resolution of that complaint. P: Survey staff shall review the hospice complaint procedure and review individual investigations, documentation, and the resolutions of complaints.	**L505**	(1) The patient has the rights: (i) To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and (ii) To not be subjected to discrimination or reprisal for exercising his or her rights.
2235	(b) Express complaints to the department, and to receive a statement provided by the department setting forth the right to and procedure for filing verbal or written complaints with the department.	G: Hospice to disseminate the Department's statement on complaint procedure to patients. The statement to include the toll-free hospice hotline telephone number and Ombudsman information. P: Survey staff to conduct home visit and/or interview selected patients or representative to assure that complaint procedure has been explained.		

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2235	(c) Be advised of the availability of a toll-free hotline, including its telephone number, to receive complaints or questions about local hospices, and be advised of the availability of the long-term care ombudsman to provide patient advocacy and other services under Wis. Stat. §16.009.			
			L506	(2) If a patient has been adjudged incompetent under state law by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed pursuant to state law to act on the patient's behalf.
			L507	(3) If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.
		G: All patient complaints and alleged or real violations included in this standard must be reported immediately to the hospice administrator and should be investigated, resolved, and documented. P: The hospice must ensure that all hospice employees and contracted staff are trained on how and when to report allegations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse by anyone furnishing services on behalf of the hospice. This includes reporting injuries of unknown origin, as well as misappropriation of property. Review employee personnel files to ensure their orientation included training on this.	**L508**	(4) The hospice must: (i) Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator
			L509	(ii) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures;

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			L510	(iii) Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency; and
			L511	iv) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation.
3005	**§ DHS 131.20 Assessment.** **(1)** INITIAL ASSESSMENT. (a) If the hospice determines that it has the general capability to meet the prospective patient's described needs, a registered nurse shall perform an initial assessment of the person's immediate needs and shall describe in writing the person's current status, including physical condition, present pain status, emotional status, pertinent psychosocial and spiritual concerns and coping ability of the prospective patient and family support system, and shall determine the appropriateness or inappropriateness of admission to the hospice based on the assessment.	G: Hospice is expected to provide a determination as to whether the prospective patient is appropriate for hospice palliative care. Once that decision has been made, the purpose of the clinical assessment is to identify palliative needs as the first step in organizing a method of intervention through the development of a plan of care. This assessment is to be done by a core team member whose skill, qualifications, and training are commensurate with clinical procedures. It is expected that the employee doing the assessment will confer with at least **one other** member of the core team prior to the development of the Initial Plan of Care. Documentation of this interaction should be recorded in the health record. P: Survey staff to review a sample of patient records to determine whether significant palliative problems noted at the time of the assessments were addressed and/ or noted in the ensuing initial plan of care.	**L522**	**418.54 (a) Standard: Initial Assessment** The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with § 418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)
3005	(b) The designated hospice employee shall confer with at least one other core team member and receive that person's views in order to start the initial plan of care.	As above.		

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3010	**(2)** TIME FRAME FOR COMPLETION OF THE COMPREHENSIVE ASSESSMENT. The hospice interdisciplinary group, in consultation with the individual's attending physician, if any, shall complete the comprehensive assessment no later than 5 calendar days after the election of hospice.		**L523**	**418.54 (b) Standard: Timeframe for completion of the comprehensive assessment.** The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with § 418.24.
3035	**(3)** CONTENT OF THE COMPREHENSIVE ASSESSMENT. The comprehensive assessment shall identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that shall be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment shall take into consideration all of the following factors:		**L524**	**418.54 (c) Standard: Content of the comprehensive assessment** The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.
3035	(a) The nature and condition causing admission including the presence or lack of objective data and subjective complaints.		**L525**	The comprehensive assessment must take into consideration the following factors: (1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).
3035	(b) Complications and risk factors that affect care planning		**L526**	(2) Complications and risk factors that affect care planning
3035	(c) Functional status, including the patient's ability to understand and participate in his or her own care.		**L527**	(3) Functional status, including the patient's ability to understand and participate in his or her own care.
3035	(d) Imminence of death.		**L528**	(4) Imminence of death.
3035	(e) Severity of symptoms.		**L529**	(5) Severity of symptoms.

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3060	(f) Drug profile. A review of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: 1. Effectiveness of drug therapy. 2. Drug side effects. 3. Actual or potential drug interactions. 4. Duplicate drug therapy. 5. Drug therapy currently associated with laboratory monitoring.		**L530**	(6) Drug profile. A review of all of the patient's prescription and over-the-county drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring.
3070	(g) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment shall be incorporated into the plan of care and considered in the bereavement plan of care.		**L531**	(7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.
3070	(h) The need for referrals and further evaluation by appropriate health professionals.		**L532**	(8) The need for referrals and further evaluation by appropriate health professionals.
3075	**(4)** UPDATE OF THE COMPREHENSIVE ASSESSMENT. The update of the comprehensive assessment shall be accomplished by the hospice interdisciplinary group in collaboration with the individual's attending physician, if any, and shall consider changes that have taken place since the initial assessment. The comprehensive assessment shall include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update shall be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. The hospice interdisciplinary group shall primarily meet in person to conduct the update of the comprehensive assessment.		**L533**	**418.54 (d) Standard: Update of the comprehensive assessment.** The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.

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3100	**(5)** PATIENT OUTCOME MEASURES. (a) The comprehensive assessment shall include data elements that allow for measurement of outcomes. The hospice shall measure and document data in the same way for all patients.		L534	**418.54 (e) Standard: Patient outcome measures** (1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.
3100	(b) The data elements shall do all of the following:		L534	"
3100	1. Take into consideration aspects of care related to hospice and palliation.		L534	"
3100	2. Be an integral part of the comprehensive assessment.		L535	(2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services and must be used in the aggregate for the hospice's quality assessment and performance improvement program.
3100	3. Be documented in a systematic and retrievable way for each patient.			
3100	(c) The data elements for each patient shall be used in individual patient care planning and in the coordination of services and shall be used in the aggregate for the hospice's quality assessment and performance improvement program.		L535	"

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3105	**§ DHS 131.21 Plan of care.** **(1)** GENERAL REQUIREMENTS. A written plan of care shall be established and maintained for each patient admitted to the hospice program and the patient's family. The hospice plan of care is a document that describes both the palliative and supportive care to be provided by the hospice to the patient and the patient's family, as well as the manner by which the hospice will provide that care. The care provided to the patient and the patient's family shall be in accordance with the plan of care.	G: Hospice shall develop an individualized plan of care for each person admitted to the program. The plan is to describe the care being provided by the hospice. Such a plan of care is to define the problem(s), the goal of care, the approaches defined to provide that care, the employee(s) identified to deliver that care, and the effect of those interventions in meeting the defined goal. In order for the plan of care to be maintained as current on each patient admitted to the program, the plan needs to be updated. P: Survey staff will conduct home visits and review a sample of active and discharged patient records. Interviews may be conducted to clarify/substantiate issues.	**L536** **L543**	**418.56 Condition of Participation: Interdisciplinary group, care planning and coordination of services.** The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions. **418.56 (b) Standard: Plan of Care** All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.
			L539	**418.56 (a) Standard: Approach to service delivery.** (1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services
			L540	(1) The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care.

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			L541	The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles: (i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice). (ii) A registered nurse. (iii) A social worker, marriage and family therapist, or a mental health counselor. (iv) A pastoral or other counselor.
			L542	(2) If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services.
			L544	(b) The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.
3130	**(2)** INITIAL PLAN OF CARE. (a) The hospice shall develop an initial plan of care that does all of the following:			
3130	1. Defines the services to be provided to the patient and the patient's family.			
3130	2. Incorporates physician orders and medical procedures.			
3130	(b) The initial plan of care shall be developed upon conclusion of the assessment under § DHS 131.20(1)(a).			

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3130	(c) The initial plan of care shall be developed jointly by the employee who performed the initial assessment and at least one other member of the core team.			
3130	(d) The registered nurse shall immediately record and sign a physician's oral orders and shall obtain the physician's counter-signature within 20 business days.		**L690**	(2)(ii) The individual receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with state and federal regulations.
3135	**(3)** PLAN OF CARE. (a) *Integrated plan of care.* The hospice core team shall develop an integrated plan of care for the new patient within 5 days after the admission. The core team shall use the initial plan of care as a basis for team decision-making and shall update intervention strategies as a result of core team assessment and planning collaboration.	G: Hospice shall update the initial plan of care developed by at least two members of the core team. The integrated plan of care shall modify and upgrade the initial plan of care as result of further assessment and greater knowledge and experience with the patient and family. The care coordinator is the facilitator of this function, and responsible for the ensuing actions taken by the hospice as a result of the documentation within this plan. P: Survey staff to conduct home visits and review a sample of active and discharged patients records.		
3165	(b) *Content of the plan of care.* The hospice shall develop an individualized written plan of care for each patient. The plan of care shall reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care shall include all services necessary for the palliation and management of the terminal illness and related conditions, including all of the following:	G: Hospice shall develop an initial plan of care based on the needs identified as a result of the assessment and conference between the two members of the core team. Identification of services to be provided shall be based on patient/family problem(s) defined and determination of goals. P: Survey staff to review a sample of active and discharged patient records. Initial surveys, review prototype of initial and integrated plans of care agency will utilize.	**L545**	**418.56 (c) Standard: Content of the plan of care.** The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:
3165	1. Interventions to manage pain and symptoms		**L546**	(1) Interventions to manage pain and symptoms.
3165	2. A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.		**L547**	(2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.

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3165	3. Measurable outcomes anticipated from implementing and coordinating the plan of care.	G: Are the hospice Plan of Care outcomes documented as measurable? Look for movement towards the expected outcomes and revisions to the Plan of Care that have been made to achieve the outcomes.	**L548**	(3) Measurable outcomes anticipated from implementing and coordinating the plan of care.
3165	4. Drugs and treatment necessary to meet the needs of the patient.		**L549**	(4) Drugs and treatment necessary to meet the needs of the patient.
3165	5. Medical supplies and appliances necessary to meet the needs of the patient.		**L550**	(5) Medical supplies and appliances necessary to meet the needs of the patient.
3165	6. The interdisciplinary group's documentation of the patient's or representatives, if any, level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.		**L551**	(6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.
3170	(c) *Review of the plan of care*. The hospice interdisciplinary group in collaboration with the individual's attending physician, if any, shall review, revise, and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. A revised plan of care shall include information from the patient's updated comprehensive assessment and shall note the patient's progress toward outcomes and goals specified in the plan of care. The hospice interdisciplinary group shall primarily meet in person to review and revise the individualized plan of care.	G: Hospice shall hold formal meetings to review and update current plans of care. Such meetings shall be held at least every 15 days or more frequently if identified in the plan and in response to a significant change of condition. Death is considered a significant change of condition; therefore, the POC must be reviewed/updated by IDG group. P: Survey staff to: • Review agency policy. • Ascertain that a schedule has been established to review each patient's plan of care at least at 15-day intervals. • Verify through documentation that core team employees have attended this review meeting. • Review a sample of patient records to determine if changes have occurred in patient's condition and review the hospice's formal response in this review of patients' plans of care. • Survey staff may observe an interdisciplinary group review meeting.	**L552** **L553**	**418.56 (d) Standard: Review of the plan of care.** The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise, and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.

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			L554	**418.56 (e) Standard: Coordination of services.** The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to— (1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided.
			L555	(2) Ensure that the care and services are provided in accordance with the plan of care.
			L556	(3) Ensure that the care and services provided are based on all assessments of the patient and family needs.
			L557	(4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.
			L558	(5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.
3190	(d) *Bereavement plan of care.* The hospice core team shall review and update the bereavement plan of care, at minimum:			
3190	1. Fifteen calendar days following a patient's death.			
3190	2. Within 60 calendar days following the patient's death.			
3190	3. As often as necessary based on identified family needs.			
3190	4. At the termination of bereavement services.			

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3215	(e) *Contents of the bereavement plan of care.* The bereavement plan of care shall include all of the following:		**L596**	(iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in 418.64(d).
3215	1. The family and caregiver's specific needs or concerns.		**L596**	(iii) Ensure that bereavement services reflect the needs of the bereaved.
3215	2. Intervention strategies to meet the identified needs.			"
3215	3. Employees responsible for delivering the care.			
3215	4. Established timeframes for evaluating and updating the interventions.			
3215	5. The effect of the intervention in meeting established goals.			
3220	(f) *Record of notes.* The core team shall develop a system for recording and maintaining a record of notes within the plan of care.	G: Hospice shall develop a procedure to record a summary of the topics discussed and IDG decisions on each patient/family as related to the plan of care review. P: Survey staff will review updated plans and/or summary meeting notes related to the review function of the plan of care. (outcome)		
3235	**§ DHS 131.22 Quality assessment and performance improvement.** **(1)** PROGRAM STANDARDS. (a) The hospice shall develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program.	G: Hospice shall establish a system to evaluate the care/services provided to its patients. The Quality Assessment and Performance Improvement (QAPI) program should monitor both the program and patient outcome. Hospice should have in place written standards of practice from which to measure its performance. P: Survey staff to verify that the hospice has developed and initiated a QAPI program.	**L559** **L560**	**418.58 Condition of Participation: Quality assessment and performance improvement.** The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program.

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3235	(b) The hospice's governing body shall ensure that the program reflects the complexity of its organization and services, involves all hospice services including those services furnished under contract or arrangement, focuses on indicators related to improved palliative outcomes, and takes actions to demonstrate improvement in hospice performance.		**L560**	The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance.
3235	(c) The hospice shall maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to the department.		**L560**	The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.
3245	**(2)** PROGRAM SCOPE. (a) The program shall at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.		**L561**	**418.58 (a) Standard: Program Scope** (1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.
3245	(b) The hospice shall measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.		**L562**	(2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.
3265	**(3)** PROGRAM DATA. (a) The program shall use quality indicator data, including patient care, and other relevant data, in the design of its program.		**L563**	**418.58 (b) Standard: Program data** (1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.
3265	(b) The hospice shall use the data collected to do all of the following:		**L564**	(2) The hospice must use the data collected to do the following:
3265	1. Monitor the effectiveness and safety of services and quality of care.		**L564**	(i) Monitor the effectiveness and safety of services and quality of care.
3265	2. Identify opportunities and priorities for improvement.		**L564**	(ii) Identify opportunities and priorities for improvement.
3265	(c) The frequency and detail of the data collection shall be approved by the hospice's governing body.		**L565**	(3) The frequency and detail of the data collection must be approved by the hospice's governing body.

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3290	**(4)** PROGRAM ACTIVITIES. (a) The hospice's performance improvement activities shall include all of the following:		**L566**	**418.58 (c) Standard: Program activities** (1) The hospice's performance improvement activities must:
3290	1. Focus on high risk, high volume, or problem-prone areas.		**L566**	(I) Focus on high risk, high volume, or problem-prone areas.
3290	2. Consider incidence, prevalence, and severity of problems in those areas.		**L567**	(ii) Consider incidence, prevalence, and severity of problems in those areas.
3290	3. Affect palliative outcomes, patient safety, and quality of care.		**L568**	(iii) Affect palliative outcomes, patient safety, and quality of care.
3290	(b) Performance improvement activities track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.		**L569**	(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.
3290	(c) The hospice shall take actions aimed at performance improvement and after implementing those actions. The hospice shall measure its success and track performance to ensure that improvements are sustained.		**L570**	(3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.
3300	**(5)** PERFORMANCE IMPROVEMENT PROJECTS. The hospice shall develop, implement, and evaluate performance improvement projects.		**L571**	**418.58 (d) Standard: Performance Improvement Projects** Beginning February 2, 2009, hospices must develop, implement, and evaluate performance improvement projects.
3300	(a) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, and shall reflect the scope, complexity, and past performance of the hospice's services and operations.		**L572**	(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.

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3300	(b) The hospice shall document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.		**L573**	(2) The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.
3315	**(6)** EXECUTIVE RESPONSIBILITIES. The hospice's governing body is responsible for ensuring all of the following:		**L574**	**418.58 (e) Standard: Executive responsibilities** The hospice's governing body is responsible for ensuring the following:
3315	(a) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually		**L574**	(1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.
3315	(b) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.		**L575**	(2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.
3315	(c) That one or more individuals who are responsible for operating the quality assessment and performance improvement program are designated.		**L576**	(3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.
3320	**§ DHS 131.23 Infection control.** **(1)** INFECTION CONTROL PROGRAM. The hospice shall maintain and document an effective infection control program that protects patients, families, visitors, and hospice employees by preventing and controlling infections and communicable diseases.		**L577**	**418.60 Condition of Participation: Infection Control** The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.
3325	**(2)** PREVENTION. The hospice shall follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.		**L579**	**418.60 (a) Standard: Prevention** The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.

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3340	**(3)** CONTROL. The hospice shall maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that:		**L580**	**418.60 (b) Standard: Control** The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that …
3340	(a) Is an integral part of the hospice's quality assessment and performance improvement program and		**L580**	(1) Is an integral part of the hospice's quality assessment and performance improvement program; and
3340	(b) Includes all of the following:		**L581**	(2) Includes the following:
3340	1. A method of identifying infectious and communicable disease problems.		**L581**	(i) A method of identifying infectious and communicable disease problems; and
3340	2. A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.		**L581**	(ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.
3350	**(4)** EDUCATION. (a) The hospice shall provide infection control education to employees, contracted providers, patients, and family members and other caregivers.		**L582**	**418.60 (c) Standard: Education** The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.
3350	(b) The hospice shall develop and implement initial orientation and ongoing education and training for all hospice workers having direct patient contact, including students, trainees, and volunteers, in the epidemiology, modes of transmission, prevention of infection and the need for routine use of current infection control measures as recommended by the U.S. centers for disease control and prevention.	G: The administration ensures orientation and training. P: Survey staff to review a sample of personnel records on orientation, training, and prevention.		

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4000	**§ DHS 131.24 Employee health.** *** (1)** DISEASE SURVEILLANCE. Agencies shall develop and implement written policies for control of communicable diseases which take into consideration control procedures incorporated by reference in ch. DHS 145 and which ensure that employees with symptoms or signs of communicable disease or infected skin lesions are not permitted to work unless authorized to do so by a physician, physician assistant or advanced practice nurse.	G: Hospice shall establish and maintain written policies for control of communicable disease; and shall establish a system for employees to use to report communicable disease. P: Survey staff shall review policies and procedures of the system, and the actions of the administration and governing body.		
4005	**(2)** PHYSICAL HEALTH OF NEW EMPLOYEES. Each new employee, prior to having direct patient contact, shall be certified in writing by a physician, physician assistant or registered nurse as having been screened for tuberculosis, and clinically apparent communicable disease that may be transmitted to a patient during the normal employee's duties. The screening shall occur within 90 days prior to the employee having direct patient contact.	P: Survey staff to review a sample of personnel records on screening for tuberculosis and clinically apparent communicable disease.		
4010	**(3)** CONTINUING EMPLOYEES. Each employee having direct patient contact shall be screened for clinically apparent communicable disease by a physician, physician assistant, or registered nurse based on the likelihood of their exposure to a communicable disease, including tuberculosis. The exposure to a communicable disease may have occurred in the community or in another location.	"		
			L 583 **L 584**	**418.62 Condition of participation: Licensed professional services.** Licensed professional services provided directly or under arrangement must be authorized, delivered, and supervised only by health care professionals who meet the appropriate qualifications specified under §418.114 and who practice under the hospice's policies and procedures.

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			L 585	Licensed professionals must actively participate in the coordination of all aspects of the patient's hospice care, in accordance with current professional standards and practice, including participating in ongoing interdisciplinary comprehensive assessments, developing, and evaluating the plan of care, and contributing to patient and family counseling and education; and;
			L586	Licensed professionals must participate in the hospice's quality assessment and performance improvement program and hospice sponsored in service training.
4015	**§ DHS 131.25 Core services.** **(1)** GENERAL REQUIREMENTS. A hospice is responsible for providing care and services to a patient and, as necessary, the patient's family, based on the plan of care developed by the core team. Volunteers shall participate in the delivery of program services.	G: Hospice shall assure that services are provided based on the plan of care. Services from volunteers are to be provided as defined in the plan of care. Within the hospice program as a whole, volunteers shall be used in both direct patient care, as well as other non-patient specific program functions. Hospice shall assure that physician and nursing services are available around the clock. Such assurance should take the form of on-call systems developed for both physician and nursing response. P: Survey staff to verify that services are provided based on the plan of care through home visits and review of a sample of patient records. In addition, survey staff to review volunteer assignments and functions within the program.	**L587**	**418.64 Condition of Participation: Core Services** A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section.

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4020	**(2)** CORE TEAM. (a) Each member of the core team shall be an employee, including a volunteer of the hospice or be under a contract with the hospice as specified in § DHS 131.25(2)(c).	G: Hospice shall assure participation of core team members in all facets of program patient-centered activities, including participation in development of patient care procedures, development, review, and updating of the patient's plan of care, and involvement in quality assurance activities. P: Survey staff may interview select core team members relative to these functions, as well as review a sample of patient records.		
4045	(b) With respect to services provided to a patient, each core team member shall do all of the following:			
4045	1. Assess patient and family needs.			
4045	2. Promptly notify the registered nurse of any change in patient status that suggests a need to update the plan of care.			
4045	3. Provide services consistent with the patient plan of care.			
4045	4. Provide education and counseling to the patient and, as necessary, to the patient's family, consistent with the plan of care.			
4045	5. Participate in developing and revising written patient care policies.		**L542**	(2) If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services.

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4050	(c) The hospice may contract for physician services as specified in § DHS 131.25(2)(a) of this section. A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. A hospice may also enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care and temporary travel of a patient outside of the hospice's service area.		**L587**	A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. A hospice may also enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice employee/staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include: unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside of the hospice's service area.
4060	**(3)** PHYSICIAN SERVICES. The hospice medical director, physician employees, and contracted physicians of the hospice, in conjunction with the patient's attending physician are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.		**L590**	**418.64 (a) Standard: Physician Services** The hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.
4060	(a) All physician employees and those under contract must function under the supervision of the hospice medical director.		**L590**	(1) All physician employees and those under contract, must function under the supervision of the hospice medical director.
4060	(b) All physician employees and those under contract shall meet this requirement by either providing the services directly or through coordinating patient care with the attending physician. If the attending physician is unavailable, the medical director, contracted physician, and or hospice physician employee is responsible for meeting the medical needs of the patient.		**L590**	(2) All physician employees and those under contract shall meet this requirement by either providing the services directly or through coordinating patient care with the attending physician. (3) If the attending physician is unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient.

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4075	**(4)** NURSING SERVICES. (a) Nursing services shall be provided by or under the supervision of a registered nurse and shall consist of all of the following:	G: Hospice shall assure that nursing services are provided by qualified individuals and that procedures have been developed delineating the responsibilities for each job category of nursing personnel, as well as for all aspects of the delivery of nursing services. P: Survey staff to review licensure status of nurse employees. In addition, survey staff will review defined nursing functions, including clinical, teaching, supervising, and evaluative aspects of this service. Method will be through a sample of patient records, home visits, use of selected interviews and review of selected personnel records.	L591	**418.64 (b) Standard: Nursing Services** (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse.
4075	1. Regularly assessing the patient's nursing needs, implementing the plan of care provisions to meet those needs and reevaluating the patient's nursing needs.		L591	Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.
4075	2. Supervising and teaching other nursing personnel, including licensed practical nurses, nurse aides.			
4075	3. Evaluating the effectiveness of delegated acts performed under the registered nurse's supervision.			
			L592	(2) If State law permits registered nurses to see, treat, and write orders for patients, then registered nurses may provide services to beneficiaries receiving hospice care.
4075	(b) Highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive, may be provided under contract.		L593	(3) Highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive, may be provided under contract.

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4075	(c) *Licensed practical nursing services.* If licensed practical nursing services are provided, the licensed practical nurse shall function under the supervision of a registered nurse with duties specified in writing and updated by a registered nurse.	G: If hospice decides to use Licensed Practical Nursing services, the position description must define that duties assigned must be under the supervision of a Registered Nurse. P: Survey staff to review position descriptions, and through a sample of patient records, review RN assignment of duties for the LPN's performance. Home visits may be conducted.		
4095	**(5)** SOCIAL SERVICES. (a) Social services shall be provided by a qualified social worker and shall consist of all of the following:	G: Hospice shall assure that the individual identified to provide social services holds a social worker certificate or clinical social worker license under s. 457.08, Wis. Stats. Hospice shall assure that social services are available for the patient and family. Social work services are provided in accordance with the Plan of Care and under the direction of a physician with physician approval. P: Survey staff to review personnel record of the assigned individual(s). Conduct clinical record reviews of patient plans of care to ensure the physician approved/signed the Plan of Care.	**L594**	**418.64 (c) Standard: Medical social services** Medical social services must be provided by a qualified social worker, under the direction of a physician.
4095	1. Regularly assessing the patient's social service needs, implementing the plan of care to meet those needs and reevaluating the patient's needs and providing ongoing psychosocial assessment of the family's coping capacity relative to the patient's terminal condition.	G: Hospice is responsible for the quality of care provided by the individual designated to deliver social services, including the psychosocial assessment and ensuing interventions to the patient and family. P: Survey staff to review a sample of patient records, conduct home visits and interview selected staff to verify patient and family psychosocial needs are met.	**L594**	Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services.
4095	2. Linking patient and family with needed community resources to meet ongoing social, emotional, and economic needs.			
	(6) COUNSELING SERVICES. Counseling services shall be available to the patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process.		**L595**	**418.64 (d) Standard: Counseling services** Counseling services must be available to the patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and dying process.

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4100	(a) *Bereavement services.* Bereavement services shall be provided to families of hospice patients. Each hospice shall have its own bereavement program. Bereavement services shall be:		**L596**	(1) Bereavement counseling. The hospice must:
4100	1. Coordinated by an individual who possesses the capacity by training and experience to provide for the bereavement needs of families, including the ability to organize a program of directed care services provided to family members. DHS 131.25 (6)	G: Hospice must establish an organized bereavement program for the purpose of providing direct bereavement care. Such care must be provided under the direction of the core team through approaches and outcomes (goals) established in the plan of care. P: Survey staff may interview the bereavement coordinator, and review a sample of bereavement records to ascertain that: • identified needs have been recognized; • approaches are compatible with bereavement needs; • actual interventions are directed by the plan of care; and • updates to the bereavement plan follow the procedures outlined for review of the plan of care. Survey staff may contact family and/or caregivers six months after their loss.	**L596**	(i) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling.

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4100	2. Compatible with the core team's direction within the plan of care for the patient.	G: While the bereavement plan is not established and implemented until death has occurred, any grief/loss issues or needs identified by hospice staff prior to death must be documented and addressed in the care plan. Neither federal nor state regulations specify a time frame for implementation of the bereavement plan following death (i.e., the next day, the following week). Implementation time frame is based on identified patient/family needs and agency policy The hospice bereavement plan of care shall be established upon assessment of loss after death and shall: • be directed by the hospice plan of care and prior assessments; • be compatible with core team directions; • reflect death related grief and loss issues/needs for family members; • include approaches and outcomes related to grief/loss issues; • specify the bereavement services to be provided and frequency of said services as defined by the hospice program; and, be updated as indicated by needs identified through hospice assessment of family needs and responses to the plan of care.	**L 596**	(iii) Ensure that bereavement services reflect the needs of the bereaved. (iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in §418.204(c).

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4100	3. Available for one year following the patient's death as part of an organized program and provide all of the following:	G: The bereavement program must provide for regular ongoing planned contact with families for at least one year after the death, which at a minimum includes offers of: • individual support contact; • access/referral to support groups; • written materials (letter, card, educational information, etc.); and • a mechanism for handling complex grief referral for counseling), etc. The hospice program services are available to the bereaved family that includes, at a minimum, the family spokesperson, immediate family, and primary caregiver(s) as identified by the patient.	**L596**	(ii) Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care.
4100	a. Orientation and training to individuals providing bereavement services to ensure that there is continuity of care.	G: Hospice shall develop procedures for orientation and training, assignment, supervision, and evaluation of direct employees or contract employees performing bereavement care. Hospice shall develop procedures to anticipate individuals that have complex grief issues and may need additional grief counseling at other community agencies (referrals). P: Survey staff may interview the bereavement coordinator and other select staff and review bereavement service procedures, in addition to review of a sample of patient records.		
4100	b. Service intervention either directly or through trained bereavement counselors			
4100	c. Assignment, supervision and evaluation of individuals performing bereavement services.			
4100	d. Referrals of family members to non-hospice community programs where appropriate.			

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4140	(b) *Dietary counseling.* Dietary counseling services shall be provided only as authorized by the hospice and in conjunction with the plan of care. The services shall be provided by a registered dietician or an individual who has documented equivalency in education or training. Dietary services shall be supervised and evaluated by a registered dietician or other individual qualified under this paragraph who may delegate acts to other employees. Dietary counseling services shall consist of all of the following:		**L597**	(2) Dietary counseling. Dietary counseling, when identified in the plan of care, must be performed by a qualified individual, which include dietitians as well as nurses and other individuals who are able to address and assure that the dietary needs of the patient are met.
4140	1. Assessment of nutritional needs and food patterns;			
4140	2. Planning diets appropriate for meeting patient needs and preferences; and			
4140	3. Providing nutrition education and counseling to meet patient needs, as well as necessary consultation to hospice employees.			
4160	(c) *Spiritual counseling.* The hospice shall do all of the following:	G: Should hospice develop this optional service, the individual providing spiritual counseling services must demonstrate the capability to perform this function as recognized by the governing body. P: Survey staff will review the personnel record of the spiritual counselor, and then review a sample of patient/family assessments performed by this individual to ascertain that the spiritual needs of patients and families are noted and acted upon. Survey staff may interview patient/family at home visits to question if spiritual counseling was offered. Should be evidence in the patient clinical record that hospice has offered and/or provided spiritual counseling in accordance with the patient/family desire.	**L598**	(1) Spiritual counseling. The hospice must:
4160	1. Provide an assessment of the patient's and family's spiritual needs.		**L598**	(i) Provide an assessment of the patients' and family's spiritual needs.

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4160	2. Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires.		**L598**	(ii) Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires.
4160	3. Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability.		**L598**	(iii) Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability.
4160	4. Advise the patient and family of this service.		**L598**	(iv) Advise the patient and family of this service.
			L599 **L600**	**418.66 Condition of participation: Nursing services**: - **Waiver of requirement that substantially all nursing services be routinely provided directly by a hospice**. (a) CMS may waive the requirement in §418.64(b) that a hospice provide nursing services directly if the hospice is located in a non-urbanized area. The location of a hospice that operates in several areas is considered to be the location of its central office. The hospice must provide evidence to CMS that it has made a good faith effort to hire a sufficient number of nurses to provide services. CMS may waive the requirement that nursing services furnished by employees based on following criteria 418.66 (a)(1-3)(b)(c)(d)
4175	**§ DHS 131.26 Non-core services.** **(1)** GENERAL REQUIREMENTS. A hospice is responsible for providing care and services to a patient and, as necessary, the patient's family, based on the plan of care developed by the core team.		**L601**	**418.70 Condition of Participation: Furnishing of non-core services.** A hospice must ensure that the services described in §418.72 through §418.78 are provided directly by the hospice or under arrangements made by the hospice as specified in §418.100. These services must be provided in a manner consistent with current standards of practice.
4175	Volunteers shall participate in the delivery of program services. The hospice may provide other services as follows:		**L644**	Volunteers must be used in day-to-day administrative and/or direct patient care roles.

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4175	(a) *Therapy services.* Therapy services are provided in accordance with the plan of care for the patient and by individuals who meet qualification requirements for therapy service delivery such as evidence of current licensure or registration and academic training. Therapy services shall consist of all of the following:	G: Should hospice decide to provide therapy services, the position descriptions shall contain duties and responsibilities, including direction of therapy assessments and interventions as directed by the patient's plan of care, and supervision by the care coordinator. P: Survey staff to review these position descriptions to review personnel qualifications and verify that direct patient interventions are compatible with the position descriptions, meet patient needs and congruent with the plan of care as determined through a review of a sample of patient records. Home visits may be conducted.	**L603** **L605-606**	**418.72 Condition of Participation: Physical therapy, occupational therapy, and speech-language pathology** Physical therapy services, occupational therapy services, and speech-language pathology services must be available and, when provided, offered in a manner consistent with accepted standards of practice. 418.74 Waiver of requirement- (a)A hospice located in a non-urbanized area may submit a written request for a waiver. See 418.74 (a)(1-2) (b)(c)
4175	1. Physical, occupational, speech and language pathology or respiratory therapy.			
4175	2. The provision of a patient assessment as directed by the plan of care.			
4175	3. The development of a therapy plan of care.			
			L 607	**418.76 Condition of Participation: Hospice aide and homemaker services.** All hospice aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Homemaker services must be provided by individuals who meet the personnel requirements specified in paragraph (j) of this section.

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4200	(b) *Homemaker services.* If homemaker services are provided, they shall be provided in accordance with the patient's plan of care and shall consist of: 1. Housekeeping activities 2. Performing errands and shopping 3. Providing transportation 4. Preparing meals. 5. Other assigned tasks intended to maintain the capacity of the household	G: Should hospice provide Homemaker services, the position description for such services must state that all services performed will be provided under the plan of care, and that assignment of these services will be done by the care coordinator. P: Survey staff will review sample of records that contain Homemaker assignments.	**L637**	**418.76(j) Standard: Homemaker qualifications.** A qualified homemaker is— (1) An individual who meets the standards in §418.202(g) and has successfully completed hospice orientation addressing the needs and concerns of patients and families coping with a terminal illness; or (2) A hospice aide as described in §418.76
			L638	**418.76(k) Standard: Homemaker supervision and duties.** (1) Homemaker services must be coordinated and supervised by a member of the interdisciplinary group.
			L639	(2) Instructions for homemaker duties must be prepared by a member of the interdisciplinary group.
			L640	(3) Homemakers must report all concerns about the patient or family to the member of the interdisciplinary group who is coordinating homemaker services

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	(2) NURSE AIDE SERVICES. The hospice may provide nurse aide services as follows:	P: Survey staff will review a sample of Hospice aide personnel records to ensure qualifications are met, and that the hospice aide has had orientation, training, and competency evaluation before providing services.	**L609**	**418.76(a) Standard: Hospice aide qualifications** (1) A qualified hospice aide is a person who has successfully completed one of the following: i. A training program and competency evaluation as specified in paragraphs (b) and (c) of this section respectively. ii. A competency evaluation program that meets the requirements of paragraph (c) of this section. iii. A nurse aide training and competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154 of this chapter and is currently listed in good standing on the State nurse aide registry. iv. A State licensure program.
			L610	(2) A hospice aide is not considered to have completed a program, as specified in paragraph (a)(1) of this section, if, since the individual's most recent completion of the program(s), there has been a continuous period of 24 consecutive months during which none of the services furnished by the individual as described in §409.40 of this chapter were for compensation. If there has been a 24month lapse in furnishing services, the individual must complete another program, as specified in paragraph (a)(1) of this section, before providing services
			L611	**418.76(b) Standard: Content and duration of hospice aide classroom and supervised practical training.** (1) Hospice aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse, or a licensed practical nurse, who is under the supervision of a registered nurse. Classroom and supervised practical training combined must total at least 75 hours.

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			L612	(2) A minimum of 16 hours of classroom training must precede a minimum of l6 hours of supervised practical training as part of the 75 hours.
			L613	(3) A hospice aide training program must address each of the following subject areas: (i) Communication skills, including the ability to read, write, and verbally report clinical information to patients, care givers, and other hospice staff. (ii) Observation, reporting, and documentation of patient status and the care or service furnished. (iii) Reading and recording temperature, pulse, and respiration. (iv) Basic infection control procedures. (v) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. (vi) Maintenance of a clean, safe, and healthy environment. (vii) Recognizing emergencies and the knowledge of emergency procedures and their application. (viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for the patient, his or her privacy, and his or her property. (ix) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist: (A) Bed bath; (B) Sponge, tub, and shower bath; (C) Hair shampoo (sink, tub, and bed); (D) Nail and skin care; (E) Oral hygiene; (F) Toileting and elimination; (x) Safe transfer techniques and ambulation. (xi) Normal range of motion and positioning. (xii) Adequate nutrition and fluid intake. (xiii) Any other task that the hospice may choose to have an aide perform. The hospice is responsible for training hospice aides, as needed, for skills not covered in the basic checklist, as described in paragraph (b)(3)(ix) of this section

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			L614	§418.76(b)(4) The hospice must maintain documentation that demonstrates that the requirements of this standard are met. Interpretive Guidelines §418.76(b)(4) A hospice aide may receive training from different organizations if the amount of training totals 75 hours, the content of training addresses all subjects listed at §418.76(b)(3) and the organization, training, instructors, and documentation meet the requirements of the regulation. Documentation of training should include: • A description of the training/competency evaluation program, including the qualifications of the instructors; • A record that indicates which skills each aide was judged to be competent and that distinguishes between skills taught at a patient's bedside with supervision, and those taught in a laboratory or simulated setting using a pseudo-patient as defined at §418.3. A pseudo-patient may be a real person trained to participate in a roleplay situation, or a computer-based mannequin device; and • How additional skills (beyond the basic skills listed in the regulation) are taught and tested if the hospice's admission policies and case-mix of hospice patients require aides to perform more complex procedures.

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			L624	§418.76(f) Standard: Eligible competency evaluation organizations. A hospice aide competency evaluation program as specified in paragraph (c) of this section may be offered by any organization except by a home health agency that, within the previous 2 years: (1) Had been out of compliance with the requirements of §484.80 of this chapter. (2) Permitted an individual that does not meet the definition of a "qualified home health aide" as specified in §484.80(a) of this chapter to furnish home health aide services (with the exception of licensed health professionals and volunteers). (3) Had been subjected to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State). (4) Had been assessed a civil monetary penalty of $5,000 or more as an intermediate sanction. (5) Had been found by CMS to have compliance deficiencies that endangered the health and safety of the home health agency's patients and had temporary management appointed to oversee the management of the home health agency. (6) Had all or part of its Medicare payments suspended. (7) Had been found by CMS or the State under any Federal or state law to have: (i) Had its participation in the Medicare program terminated. (ii) Been assessed a penalty of $5,000 or more for deficiencies in Federal or State standards for home health agencies. (iii) Been subjected to a suspension of Medicare payments to which it otherwise would have been entitled. (iv) Operated under temporary management that was appointed by a governmental authority to oversee the operation of the home health agency and to ensure the health and safety of the home health agency's patients. (v) Been closed by CMS or the State, or had its patients transferred by the State.

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4205	(a) *Assignment.* Nurse aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a nurse aide shall be prepared by a registered nurse who is responsible for the supervision of a nurse aide as specified under paragraph (c) of this section.	P: Survey staff to conduct home visits and/or select sample of patient records that contain Hospice aide assignments. Ensure hospice aides have written instruction and plan of care for the patient conducted.	**L625**	**418.76(g) Standard: Hospice aide assignments and duties** Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.
4245	(b) *Plan of Care.* The nurse aide shall provide care in accordance with the patient's plan of care. Nurse aide services consist of, but are not to be limited to, all of the following:	G: Ensure that Hospice aide plans of care duties and hands on care are not beyond the scope of aide services under State law.	**L626**	(2) A hospice aide provides services that are: (i) Ordered by the interdisciplinary group. (ii) Included in the plan of care. (iii) Permitted to be performed under State law by such hospice aide. (iv) Consistent with the hospice aide training.
4245	1. Assisting patients with personal hygiene.		**L627**	(1) The duties of a hospice aide include the following: (i) The provision of hands-on personal care. (ii) The performance of simple procedures as an extension of therapy or nursing services.
4245	2. Assisting patients into and out of bed and with ambulation.		**L627**	(iii) Assistance in ambulation or exercises.
4245	3. Assisting with prescribed exercises which patients and hospice aides have been taught by appropriate health care personnel.		**L627**	"
4245	4. Assisting patients to the bathroom or in using a bedpan.			
4245	5. Assisting patients with self-administration of medications.		**L627**	(iv) Assistance in administering medications that are ordinarily self-administered.

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4245	6. Administering medications to patients if the aide has completed a state-approved medications administration course and has been delegated this responsibility in writing for the specific patient by a registered nurse.			
4245	7. Reporting changes in the patient's condition and needs.		**L628**	(4) Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities.
4245	8. Completing appropriate records.		**L628**	Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures.
4265	(c) *Supervision of nurse aides.* 1. A registered nurse shall make an on-site visit to the patient's home no less frequently than every 14 days to assess the quality of care and services provided by the nurse aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The nurse aide does not have to be present during this visit.	G: If hospice decides to provide Hospice aide services, the position descriptions shall contain defined duties and include the procedures for written assignments, and direction by an RN. Supervision by an RN to be provided every 14 days. P: Survey staff to conduct home visits and select sample of patient records that contain Hospice aide assignments. A review of those assignment and RN supervision will be conducted.	**L629**	**418.76(h) Standard: Supervision of hospice aides** (1) A registered nurse must make an on-site visit to the patient's home: (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.
4265	2. If an area of concern is noted by the supervising nurse, then the hospice shall make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while the aide is performing care.		**L630**	(ii) If an area of concern is noted by the supervising nurse, then the hospice must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care.
4265	3. If an area of concern is verified by the hospice during the on-site visit, then the hospice shall conduct, and the nurse aide shall complete a competency evaluation.		**L631**	(iii) If an area of concern is verified by the hospice during the on-site visit, then the hospice must conduct, and the hospice aide must complete, a competency evaluation of the deficient skill and all related skill(s) accordance with 418.76(c).
4265	4. A registered nurse shall make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while the aide is performing care.		**L632**	(2) A registered nurse must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.

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4290	(d) *Assessment of aide.* The supervising nurse shall assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include all of the following, but is not limited to: 1. Following the patient's plan of care for completion of tasks assigned to the nurse aide by the registered nurse. 2. Creating successful interpersonal relationships with the patient and family. 3. Demonstrating competency with assigned tasks. 4. Complying with infection control policies and procedures. 5. Reporting changes in the patient's condition.		**L633**	(3) The supervising nurse must assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include, but not limited to- (i) Following the patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse. (ii) Creating successful interpersonal relationships with the patient and family. (iii) Demonstrating competency with assigned tasks. (iv) Complying with infection control policies and procedures. (v) Reporting changes in the patient's condition.
			L634	§418.76(i) Standard: Individuals furnishing Medicaid personal care aide-only services under a Medicaid personal care benefit. An individual may furnish personal care services, as defined in §440.167 of this chapter, on behalf of a hospice agency. §418.76(i)(1) Before the individual may furnish personal care services, the individual must be found competent by the State (if regulated by the State) to furnish those services. The individual only needs to demonstrate competency in the services the individual is required to furnish.

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			L635	§418.76(i)(2) Services under the Medicaid personal care benefit may be used to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care.
			L636	§418.76(i)(3) The hospice must coordinate its hospice aide and homemaker services with the Medicaid personal care benefit to ensure the patient receives the hospice aide and homemaker services he or she needs. Interpretive Guidelines §418.76(i)(3) It is up to the State to define the optional Medicaid State Plan personal care services benefit and to determine if the benefit is more extensive than the homemaker/hospice aide benefit provided under the Medicare hospice benefit. If the Medicaid personal care services benefit is more extensive than what is offered under the Medicare hospice benefit, proper coordination of services must occur. In this instance, the State must pay for covered Medicaid personal care services that exceed the scope of the Medicare hospice benefit when a need for those personal care services is indicated in the patient's hospice plan of care.

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4295	**§ DHS 131.27 Volunteers.** Prior to beginning patient care, a volunteer shall be oriented to the hospice program and shall have the training for the duties to which he or she is assigned. .	G: Hospice shall establish procedures for volunteer orientation to both the hospice program, as well as specific training for any individual duties that the volunteer may be assigned. Volunteers may be used in direct patient functions, as well as non-patient activities within the hospice program. P: Survey staff to review volunteer orientation as well as volunteer assignments. Select interviews may be conducted.	**L641**	**418.78 Conditions of Participation: Volunteers** The hospice must use volunteers to the extent specified in paragraph (e) of this section. These volunteers must be used in defined roles and under the supervision of a designated hospice employee.
			L643	**418.78(a) Standard: Training** The hospice must maintain, document, and provide volunteer orientation and training that is consistent with hospice industry standards.
			L644	**418.78(b) Standard: Role** Volunteers must be used in day-to-day administrative and/or direct patient care roles.
			L645	**418.78(c) Standard: Recruiting and retaining** The hospice must document and demonstrate viable and ongoing efforts to recruit and retain volunteers

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			L646	**418.78(d) Standard: Cost saving** The hospice must document the cost savings achieved through the use of volunteers. Documentation must include the following: (1) The identification of each position that is occupied by a volunteer. (2) The work time spent by volunteers occupying those positions. (3) Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions identified in paragraph (d)(1) of this section for the amount of time specified in paragraph (d)(2) of this section.
			L647	**418.78(e) Standard: Level of activity** Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked.
			L648	**418.100 Condition of Participation: Organization and administration of services** The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers, and families necessary for the palliation and management of the terminal illness and related conditions
			L650	**418.100(a) Standard: Serving the hospice patient and family**. The hospice must provide hospice care that- (1) Optimizes comfort and dignity; and Is consistent with patient and family needs and goals, with patient needs and goals as priority.

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4330	**§ DHS 131.28 Governing body.** **+ * (1)** Each hospice shall have a governing body that assumes full legal responsibility for determining, implementing, and monitoring the overall conduct and operation of the program, including the quality of the care and services.	G: Hospice must demonstrate that there is a designated individual, group or corporation with the responsibility and authority in writing for the day-to-day operation of the hospice. The governing body must establish policies that encompass the full operation and evaluation of the hospice program. P: Survey staff to: • Review charter, by-laws, or other documents to determine the legal responsibility for hospice care; • Establish that the governing body has developed policies regarding the hospice's full operation, including evaluation of those policies and program effectiveness.	**L651**	**418.100(b) Standard: Governing body and administrator** A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body.
	(2) The governing body shall do all of the following:			
4335	* (a) Be responsible for the establishment and maintenance of policies and for the management, operating and evaluation of the hospice.		**L651**	
4335	(b) Adopt a statement that designates the services the hospice will provide and the setting or settings in which the hospice will provide care.		**L651**	
4335	+ (c) Ensure that all services are provided consistent with accepted standards of professional practice.		**L652**	**418.100 (c) Standard: Services.** (1) A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice: (i) Nursing services. (ii) Medical social services. (iii) Physician services. (iv) Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling. (v) Hospice aide, volunteer, and homemaker services. (vi) Physical therapy, occupational therapy, and speech-language pathology services. (vii) Short-term inpatient care. (viii) Medical supplies (including drugs and biologicals) and medical appliances.

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4335	* (d) Appoint an administrator and delegate to the administrator the authority to operate the hospice in accordance with policies established by the governing body.		**L651**	
4335	+ (e) Ensure that nursing and physician services and drugs and biologicals are routinely available on a 24-hour basis 7 days a week.	P: Review on-call system developed by the hospice.	**L653**	(2) Nursing services, physician services, and drugs and biologicals (as specified in § 418.106) must be made routinely available on a 24-hour basis 7 days a week. Other covered services must be available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family.
4335	+ (f) Ensure that other covered services are available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family.			"
4360	**§ DHS 131.29 Administration.** **(1)** ADMINISTRATOR. The administrator shall be responsible for day-to-day operation of the hospice.	G: The Administrator shall play an active role in implementing policies, evaluating hospice performance, and establishing a functional organizational structure. P: Survey staff to interview the administrator in order to determine the role of the administrator in organizing, implementing, and evaluating policies of the program.	**L651**	
	(2) DUTIES OF THE ADMINISTRATOR. The administrator shall do all of the following:			
4365	(a) Implement and regularly evaluate policies for the management and operation of the hospice and evaluation of the overall program performance of the hospice and implement and regularly evaluate procedures consistent with those policies.			
4365	(b) Establish an organizational structure appropriate for directing the work of the hospice's employees in accordance with the program's policies and procedures.			
4365	(c) Maintain a continuous liaison between the governing body and the hospice employees.			

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4365	(d) Ensure that employees are oriented to the program and their responsibilities, that they are continuously trained and that their performance is evaluated.	G: Hospice administrator to ensure that the system developed provides for adequate orientation, training, and performance evaluation of hospice employees. P: Survey staff to review personnel records of selected employees for evidence of orientation, training, and evaluation.		
4365	+ (e) Designate in writing, with the knowledge of the governing body, a qualified person to act in his or her absence.	G: The administrator is to set up a procedure for an alternate administrator to act in the administrator's absence. P: Survey staff to review who is the alternate administrator designation by governing body.		
4370	**§ DHS 131.30 Professional management responsibility.** **(1)** RESPONSIBILITY. The hospice is responsible for providing services to the patient or family, or both, based on assessed need and as established by the plan of care.	G: Self explanatory P: Survey staff will assure that hospice has assumed responsibility to manage services provided to the patient or family as defined in the plan of care.	**L655**	**418.100(e) Standard: Professional management responsibility.** A hospice that has a written agreement with another agency, individual, or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care. Arranged services must be supported by written agreements that require that all services be … (1) Authorized by the hospice; (2) Furnished in a safe and effective manner by qualified personnel; and (3) Delivered in accordance with the patient's plan of care.
4400	**+ (2)** CONTRACT SERVICES. The hospice may contract with other providers for the provision of services to a patient or the patient's family, or both, in which case the hospice shall retain responsibility for the quality, availability, safety, effectiveness, documentation and overall coordination of the care provided to the patient or the patient's family, or both, as directed by the hospice plan of care. The hospice shall:	G: If hospice shall provide services under contract, these services shall be described by a legally binding written agreement between the hospice and the source of the service. P: Survey staff to review this process through a sample of patient records, as well as reviewing a sample of contract language for hospice's retaining responsibility for contracted services provided. Request a listing of contractees for sample selection. For initial survey request a contract prototype for review.	**L762**	**418.112(b) Standard: Professional management.** The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to 418.110 and 418.108.

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4400	(a) Ensure that there is continuity of care for the patient or the patient's family, or both, in the relevant care setting.	G: Hospice shall provide smooth provision of services within a defined care setting, or from one location (setting) to another. P: Survey staff shall review a sample of patient records and conduct home visits to assure that continuity of care has occurred in the relevant care setting.		
4405	(b) Be responsible for all services delivered to the patient or the patient's family, or both, through the contract. The written contract shall include all of the following:	G: The hospice shall retain the program and clinical responsibility for services provided to the patient/family under the terms of this agreement. The hospice plans for the patient's care, assures management for, and retains responsibility of that care. The hospice must assure that services offered are consistent with the hospice philosophy of palliative and supportive care. The contract specifies the services to be provided, personnel qualifications, the role and responsibility of each party, and a stipulation that all services provided will be in accordance with the direction defined in the hospice's plan of care. P: Survey staff to review contract for language compliance. Selected interviews with contractors may be conducted, if warranted.	**L763**	The hospice and SNF/NF or ICF/MR must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by authorized representatives of the hospice and the SNF/NF or ICF/MR before the provision of hospice services.
4405	1. Identification of the services to be provided.		**L767**	An agreement that it is the SNF/NF or ICF/MR responsibility to continue to furnish 24-hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected.
4405	2. Stipulation that services are to be provided only with the authorization of the hospice and as directed by the hospice plan of care for the patient.		**L776**	Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/MR representatives, and must be approved by the hospice before implementation.

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4405	3. The manner in which the contracted services are coordinated and supervised by the hospice.		**L776**	A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
4405	4. The delineation of the roles of the hospice and service provider in the admission process, assessment, interdisciplinary group meetings and ongoing provision of palliative and supportive care.		**L769**	A delineation of the hospice's responsibilities, which include, but are not limited to the following providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary and bereavement); social work; provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
4405	5. A method of evaluation of the effectiveness of those contracted services through the quality assurance program under § DHS 131.22.		**L560**	The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

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4405	6. The qualifications of the personnel providing the services.		**L784** **L703**	Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified, or registered) in accordance with applicable federal, state and local laws, and must act only within the scope of his or her state license, or state certification, or registration. All personnel qualifications must be kept current at all times. §418.106(f)(3) Hospices may only contract for durable medical equipment services with a durable medical equipment supplier that meets the Medicare DMEPOS Supplier Quality and Accreditation Standards at 42 CFR §424.57.
4410	(c) Evaluate the services provided under a contractual arrangement on an annual basis.	G: The hospice must annually evaluate services provided under contractual arrangements to ensure contract compliance and outcomes of patient care. P: Survey staff will review a sample of contract evaluations. (Outcome)		
			NOTE: ***There may be alternate requirements at 42 CFR 418.100 more appropriate in specific situations than those referenced above as related to § DHS 131.30.***	

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4415	**§ DHS 131.31 Employees.** **(1)** CAREGIVER BACKGROUND CHECKS. Each hospice shall comply with the caregiver background check and misconduct reporting requirements in Wis. Stat. § 50.065 and ch. DHS 12, and the caregiver misconduct reporting and investigation requirements in ch. DHS 13. (see also Z-tags 0005)		L795	**418.114 (d) Standard: Criminal background checks.** (1) The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records. (2) Criminal background checks must be obtained in accordance with State requirements.
4440	**(2)** GENERAL REQUIREMENTS. Prior to beginning patient care, every employee or contracted staff shall be oriented to the hospice program and the job to which he or she is assigned.	G: Hospice shall establish both general orientation as well as specific job-focused training. Orientation and training shall be established by policy. Hospice shall, based on orientation and training, assign only those duties for which the employee demonstrates competency. (Outcome) P: Survey staff to review hospice orientation and training through review of selected personnel records to affirm that employees received an orientation and demonstrated competency in specific duties prior to assignment. Selected staff may be interviewed.	L661 L662	(1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact. (2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties.
	(3) ORIENTATION PROGRAM. A hospice's orientation program shall include all of the following:			**418.100(g) Standard: Training**:
4445	* (a) An overview of the hospice's goal in providing palliative care.		L661	(1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact
4445	* (b) Policies and services of the program.			
4445	* (c) Information concerning specific job duties.		L662	(2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties.

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4445	* (d) The role of the plan of care in determining the services to be provided.			
4445	* (e) Ethics, confidentiality of patient information, patient rights, and grievance procedures.			
4450	* **(4)** DUTIES. Hospice employees or contracted staff may be assigned only those duties for which they are capable, as evidenced by documented training or possession of a license or certificate.			
4455	* **(5)** CONTINUOUS TRAINING. A program of continuing training directed at maintenance of appropriate skill levels shall be provided for all hospice employees providing services to patients and their families.	G: Hospice shall provide a program of continuing training to all hospice employees to ensure maintenance of appropriate skill levels.	**L663**	(3) A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months.
4465	**(6)** EVALUATION. A hospice shall evaluate every employee annually for quality of performance and adherence to the hospice's policies. Evaluations shall be followed up with appropriate action.	G: Hospice shall establish procedures for the annual evaluation of employees. P: Survey staff shall review selected employee performance evaluations. The sample may include the administrator, core team members and contracted staff.	**L660**	2) The hospice must continually monitor and manage all services provided at all of its locations to ensure that services are delivered in a safe and effective manner and to ensure that each patient and family receives the necessary care and services outlined in the plan of care, in accordance with the requirements of this subpart and subparts A and C of this section.
4470	**(7)** PERSONNEL PRACTICES. (a) Hospice personnel practices shall be supported by appropriate written personnel policies.			
4470	(b) Personnel records shall include evidence of qualifications, licensure, performance evaluations and continuing training, and shall be kept up-to-date.	P: Survey staff shall review a selected sample of personnel records for evidence of qualifications and/or licensure.		

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4505	**§ DHS 131.32 Medical Director.** **(1)** The hospice shall have a medical director who shall be a medical doctor or a doctor of osteopathy.	G: Hospice shall assure that the medical director has assumed the overall responsibility for direction for the medical components of the program, and that s/he ensures the terminal status of each individual admitted to the program. P: Survey staff to: • Review personnel folder of medical director to verify qualifications, and • Review sample of patient records to verify that the medical director has concurred with the prognostic status of the patient at the time of admission.	**L664**	**418.102 Condition of Participation: Medical Director** The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with, the hospice. When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director.
			L666	**418.102 (a)Standard: Medical director contract.** (1) A hospice may contract with either of the following— (i) A self-employed physician; or (ii) A physician employed by a professional entity or physicians' group. When contracting for medical director services, the contract must specify the physician who assumes the medical director responsibilities and obligations.
	(2) The medical director shall do all of the following:			
4510	(a) Direct the medical components of the program.		**L669**	**418.102 (d) Standard Medical director responsibility:** The medical director or physician designee has responsibility for the medical component of the hospice's patient care program.

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4510	(b) Ensure that the terminal status of each individual admitted to the program has been established.		**L667**	**418.102 (b) Standard: Initial Certification of terminal illness.** The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that it is anticipated that the patient's life expectancy is 6 months or less if the illness runs its normal course. The physician must consider the following when making this determination: (1) The primary terminal condition; (2) Related diagnosis(es), if any; (3) Current subjective and objective medical findings; (4) Current medication and treatment orders; and (5) Information about the medical management of any of the patient's conditions unrelated to the terminal illness.
			L 668	**418.102 (c) Standard: Recertification of the terminal illness.** Before the recertification period for each patient, as described in § 418.21(a), the medical director or physician designee must review the patient's clinical information.

4510	(c) Ensure that medications are used within accepted standards of practice. (d) Ensure that a system is established and maintained to document the disposal of controlled drugs. (g) Ensure that a system is established for the disposal of controlled drugs.	G: Hospice shall assure that the medical director through the role of directing the medical component of the program ensures that medications are used within accepted standards, that a system has been developed to document the disposal of controlled substances, and ensures that the medical needs of the patients are being met. P: Survey staff to review medication usage and disposal through sample selection of patient records, as well as review policy for the disposal of controlled substances.	**L686** **L688** **L690**	§418.106 Condition of participation: Drugs and biologicals, medical supplies, and durable medical equipment. Medical supplies and appliances, as described in §410.36 of this chapter; durable medical equipment, as described in §410.38 of this chapter; and drugs and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care. §418.106(a) Standard: Managing drugs and biologicals. (1) A hospice that provides inpatient care directly in its own facility must provide pharmacy services under the direction of a qualified licensed pharmacist who is an employee of or under contract with the hospice. The provided pharmacist services must include evaluation of a patient's response to medication therapy, identification of potential adverse drug reactions, and recommended appropriate corrective action. §418.106(b) Standard: Ordering of drugs. (1) Drugs may be ordered by any of the following practitioners: (i) A physician as defined by Section 1861(r)(1) of the Act, (ii) A nurse practitioner in accordance with state scope of practice requirements. (iii) A physician assistant in accordance with the state scope of practice requirements and hospice policy who is: (A) The patient's attending physician; and (B) Not an employee of or under arrangement with the hospice. (2) If the drug order is verbal or given by or through electronic transmission— (i) It must be given only to a licensed nurse, nurse practitioner (where appropriate), pharmacist, or physician; and (ii) The individual receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with State and Federal regulations.

4510			**L691**	§418.106(c) Standard: Dispensing of drugs and biologicals. The hospice must— (1) Obtain drugs and biologicals from community or institutional pharmacists or stock drugs and biologicals itself. (2) The hospice that provides inpatient care directly in its own facility must: (i) Have a written policy in place that promotes dispensing accuracy; and (ii) Maintain current and accurate records of the receipt and disposition of all controlled drugs.
			L692	§418.106(d) Standard: Administration of drugs and biologicals. (1) The interdisciplinary group, as part of the review of the plan of care, must determine the ability of the patient and/or family to safely self-administer drugs and biologicals to the patient in his or her home. (2) Patients receiving care in a hospice that provides inpatient care directly in its own facility may only be administered medications by the following individuals: (i) A licensed nurse, physician, or other health care professional in accordance with their scope of practice and State law; (ii) An employee who has completed a State-approved training program in medication administration; and (iii) The patient, upon approval by the interdisciplinary group.
			L693	§418.106(e) Standard: Labeling, disposing, and storing of drugs and biologicals (1) Labeling. Drugs and biologicals must be labeled in accordance with currently accepted professional practice and must include appropriate usage and cautionary instructions, as well as an expiration date (if applicable).

4510			**L694**	§418.106(e)(2) Disposing. (i) Safe use and disposal of controlled drugs in the patient's home. The hospice must have written policies and procedures for the management and disposal of controlled drugs in the patient's home. At the time when controlled drugs are first ordered the hospice must:
			L695	§418.106(e)(2)(A) - Provide a copy of the hospice written policies and procedures on the management and disposal of controlled drugs to the patient or patient representative and family;
			L696	§418.106(e)(2)(B) - Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; and
			L697	§418.106(e)(2)(C) - Document in the patient's clinical record that the written policies and procedures for managing controlled drugs was provided and discussed.
			L698	§418.106(e)(2)(C)(ii) - Disposal of controlled drugs in hospices that provide inpatient care directly. The hospice that provides inpatient care directly in its own facility must dispose of controlled drugs in compliance with the hospice policy and in accordance with State and Federal requirements. The hospice must maintain current and accurate records of the receipt and disposition of all controlled drugs.

4510			**L699**	§418.106(e)(3) Storing. The hospice that provides inpatient care directly in its own facility must comply with the following additional requirements- (i) All drugs and biologicals must be stored in secure areas. All controlled drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1976 must be stored in locked compartments within such secure storage areas. Only personnel authorized to administer controlled drugs as noted in paragraph (d)(2) of this section may have access to the locked compartments; and
			L700	§418.106(e)(3)(ii) Discrepancies in the acquisition, storage, dispensing, administration, disposal, or return of controlled drugs must be investigated immediately by the pharmacist and hospice administrator and where required reported to the appropriate State authority. A written account of the investigation must be made available to State and Federal officials if required by law or regulation.

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4510	(e) Ensure that the medical needs of the patients are being met.			
4510	(f) Provide liaison as necessary between the core team and the attending physician.			
4515	**§ DHS 131.33 Clinical record.** **(1)** GENERAL. A hospice shall establish a single and complete clinical record for every patient. Clinical record information shall remain confidential except as required by law or a third-party payment contract.	G: The hospice must maintain a single, complete clinical record for each individual admitted to the hospice. The record reflects the course and effects of services/events with respect to the patient's illness. P: The survey staff to review a sample of patient records.	**L670** **L680**	**418.104 Condition of Participation: Clinical records.** A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically. The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use.
4595	*** (2)** DOCUMENTATION AND ACCESSIBILITY. The clinical record shall be completely accurate and up-to-date, readily accessible to all individuals providing services to the patient or the patient's family, or both, and shall be systematically organized to facilitate prompt retrieval of information.	G: Hospice shall assure that all information pertinent to patient/family care is documented in such a manner to assure accuracy. Such information needs to be retrievable by all employees in a timely manner so that patient/family needs can be determined and acted on by the hospice employees. Hospice shall develop health care policies that ensure record information is safeguarded. P: Survey staff to verify, through record review, that all services (direct or under contract) are documented, and that this documentation system allows for accessibility to all employees. Survey staff may verify that the storage area for records affords protection from fire, water, and environmental threats.	**L671** **L685**	A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically. The clinical record, whether hard copy or in electronic form, must be made readily available on request by an appropriate authority.

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	(3) CONTENT. A patient's clinical record shall contain all of the following:	G: Hospice shall assure every patient record contains all information outlined in 131.33(3)(a) through (m). With respect to (3)(e), the language, "a current medication list", refers to both prescribed medication as well as over-the-counter medications that the patient is taking. P: To review a select sample of health care records to survey staff, verify the content.	**L672**	**418.104 (a) Standard: Content** Each patient's record must include the following:
4600	(a) The initial, integrated, and updated plans of care prepared under § DHS 131.21		**L672**	(1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.
4600	(b) The initial, comprehensive, and updated comprehensive assessments.		**L672**	"
4600	(c) Complete documentation of all services provided to the patient or the patient's family or both, including:			
4600	1. Assessments.		**L672**	"
4600	2. Interventions.			
4600	3. Instructions given to the patient or family, or both.		**L702**	§418.106(f)(2) The hospice must ensure that the patient, where appropriate, as well as the family and/or other caregiver(s), receive instruction in the safe use of durable medical equipment and supplies. The hospice may use persons under contract to ensure patient and family instruction. The patient, family, and/or caregiver must be able to demonstrate the appropriate use of durable medical equipment to the satisfaction of the hospice staff. Interpretive Guidelines §418.106(f)(2)

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4600	4. Coordination of activities.		**L701**	§418.106(f) Standard: Use and maintenance of equipment and supplies (1) The hospice must ensure that manufacturer recommendations for performing routine and preventive maintenance on durable medical equipment are followed. The equipment must be safe and work as intended for use in the patient's environment. Where a manufacturer recommendation for a piece of equipment does not exist, the hospice must ensure that repair and routine maintenance policies are developed. The hospice may use persons under contract to ensure the maintenance and repair of durable medical equipment.
4600	(d) Signed copies of the notice of patient rights under § DHS 131.19(1)(a) and service authorization statement under § DHS 131.17(4)(b).		**L673**	(2) Signed copies of the notice of patient rights in accordance with 418.52 and election statement in accordance with 418.24.
4600	(e) A current medications list.			
4600	(f) Responses to medications, symptom management, treatments, and services.		**L674**	(3) Responses to medications, symptom management, treatments, and services.
4600	(g) Outcome measure data elements, as described in § DHS 131.20(5).		**L675**	(4) Outcome measure data elements, as described in 418.54(e) of this subpart.
4600	(h) Physician certification and recertification of terminal illness.		**L676**	(5) Physician certification and recertification of terminal illness as required in 418.22 and 418.25 and described in 418.102(b) and 418.102(c) respectively, if appropriate.
4600	(i) A statement of whether or not the patient, if an adult, has prepared an advance directive; and a copy of the advance directive, if prepared.		**L677**	(6) Any advance directives as described in 418.52(a)(2).
4600	(j) Physician orders.		**L678**	(7) Physician orders.
4600	(k) Patient and family identification information.			
4600	(L) Referral information, medical history, and pertinent hospital discharge summaries.			

P Tag	STATE RULE – Chapter DHS 131 * = Agency Policy Required + = Additional Documentation Required	STATE Interpretive Guidelines (G) Surveyor Procedures (P)	L Tag	FEDERAL Conditions of Participation Requirement
4600	(m) Transfer and discharge summaries.			
4605	**(4)** AUTHENTICATION. (a) *Entries.* All entries shall be legible, permanently recorded, dated, and authenticated by the person making the entry, and shall include that person's name and title.		**L679**	All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.
4605	(b) *Written record*. A written record shall be made for every service provided on the date the service is provided. This written record shall be incorporated into the clinical record no later than seven calendar days after the date of service.	G: Hospice shall assure that employees document patient and family information in such a manner that the document developed by the employees can be available to all employees within the hospice program. All entries need to be signed by the person making the entry. The use of initials is acceptable provided there is an indication the record identifies the initials with the signer's signature and title. Photocopies are considered a legal document.		
4605	(c) *Medical symbols*. Medical symbols and abbreviations may be used in the clinical records if approved by a written program policy which defines the symbols and abbreviations and controls their use.	G: The hospice must have an approved policy outlining symbols and abbreviations that may be used by employees. P: Surveyors will verify through record review, that staff adheres to agency policy.		
4605	(d) *Protection of information.* Written record policies shall ensure that all record information is safeguarded against loss, destruction, and unauthorized usage.		**L680**	The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use.
4605	(e) *Retention and destruction.* 1. An original clinical record and legible copy or copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of the patient shall be retained for a period of at least five years following a patient's discharge or death when there is no requirement in state law. All other records required by this chapter shall be retained for a period of at least two years.		**L681**	Patient clinical records must be retained for 6 years after the death or discharge of the patient, unless State law stipulates a longer period of time. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform its state agency and its CMS Regional Office where such clinical records will be stored and how they may be accessed.
4605	2. A hospice shall arrange for the storage and safekeeping of records for the periods and under the conditions required by this paragraph in the event the hospice closes.		**L681**	"

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4605	3. If the ownership of a hospice changes, the clinical records and indexes shall remain with the hospice.			
			L682	**418.104 (e) Standard: Discharge or transfer of care.** (1) If the care of a patient is transferred to another Medicare/Medicaid-certified facility, the hospice must forward to the receiving facility, a copy of— (i) The hospice discharge summary; and (ii) The patient's clinical record, if requested.
			L683	(2) If a patient revokes the election of hospice care, or is discharged from hospice in accordance with § 418.26, the hospice must forward to the patient's attending physician, a copy of— (i) The hospice discharge summary; and (ii) The patient's clinical record, if requested.
			L684	(3) The hospice discharge summary as required must include— (i) A summary of the patient's stay including treatments, symptoms, and pain management. (ii) The patient's current plan of care. (iii) The patient's latest physician orders. and (iv) Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.
4640	**§ DHS 131.34 Personnel Qualifications.** **(1)** PERSONNEL QUALIFICATIONS. All professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, shall be legally authorized, licensed, certified, or registered in accordance with applicable federal, state and local laws, and shall act only within the scope of his or her state licensure, or state certification, or registration		**L783** **L784**	**418.114 Condition of Participation: Personnel qualifications** (a) Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified, or registered) in accordance with applicable federal, state and local laws, and must act only within the scope of his or her state license, or state certification, or registration. All personnel qualifications must be kept current at all times.

P Tag	STATE RULE – Chapter DHS 131 * = Agency Policy Required + = Additional Documentation Required	STATE Interpretive Guidelines (G) Surveyor Procedures (P)	L Tag	FEDERAL Conditions of Participation Requirement
				(b) Personnel qualifications for certain disciplines. The following qualifications must be met:
			L785	(1) Physician.
			L786	(2) Hospice aide.
			L787	(2) Social worker.
			L788	(3) Speech language pathologist.
			L789	(4) Occupational therapist.
			L790	(5) Occupational therapy assistant.
4640	Personnel qualifications shall be kept current at all times.		L791	(6) Physical therapist.
			L792	(7) Physical therapy assistant
				(c) Personnel qualifications when no State licensing, certification or registration requirements exist. If no State licensing laws, certification or registration requirements exist for the profession, the following requirements must be met:
			L793	(1) Registered nurse. A graduate of a school of professional nursing.
			L794	(2) Licensed practical nurse. A person who has completed a practical nursing program.