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in this issue

Hospice Social Workers

The Journal

Change!

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The old saying goes, "Nothing is certain except death and taxes." Actually that is not a complete statement of the truth. A corollary notes that the only thing you can count on to remain the same in this life is change. The latter is certainly true when it comes to government regulations. As a professor who teaches social welfare policy, I have noted that most policies reflect something of a "tug of war" between two primary groups who have different priorities and philosophies. Sadly, changes are often not about what is really best for those affected, but rather about which group's priorities are in vogue.

A good example of such a "tug of war" is the ever-changing regulations concerning hospice care. One way to characterize the two opposing philosophies might be to note that one group tends to be deeply rooted in the original assumptions of the modern hospice movement. Dame Cicely Saunders and our American Hospice pioneers sought to create the best possible service vehicle for persons nearing the end of life and for their loved ones. They recognized that the purely "medical model" did not serve this population well. Just as women have demanded that physicians recognize that the birthing event is about more than just "the plumbing", these pioneers recognized that the dying event is more than just a sterile, medical event. Their model envisioned a truly interdisciplinary group of the best professionals, offering a holistic, multi-faceted assessment and care plan, and interventions based primarily upon the wishes and priorities of the patient. As Saunders (trained as a nurse, a social worker, and a physician) often said, this was not a medical model, but a social work model of care.

The second group tends to look upon the first group as hopelessly idealistic . This group is much more concerned about the "business" of hospice, and certainly seems to be shaping hospice care today. While this may seem a great oversimplification, the most visible expression of this emphasis is the questioning of whether social work and chaplaincy really have any value in today's hospice. The concern of the old-timers is that what was unique and wonderful about hospice is in danger of getting lost in countless reports, computer programs, and other expressions of managed care (a real misnomer if ever there was one!).

Now, like most complex issues, this "tug of war" analogy is not so simple. Budgets, requirements for accountability, and a sharply rising chunk of the federal budget over recent

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The Louisiana-Mississippi Hospice and Palliative Care Organization is a 501(c)3 non-profit organization governed by a board of directors representing all member hospice programs. It is funded by membership dues, grants, tax-deductible donations and revenues generated by educational activities. LMHPCO exists to ensure the continued development of hospice and palliative care services in Louisiana and Mississippi. LMHPCO provides public awareness, education, research, and technical assistance regarding end-of-life care, as well as advocacy for terminally ill and bereaved persons, striving to continually improve the quality of end-of-life care in Louisiana and Mississippi.

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years demand some attention to these matters. However, I cannot help but be reminded of an article Gary Gardia wrote in the old Hospice Journal some years ago. He questioned whether the "Heart" of hospice could be maintained in an age of "Managed Care". Some believe that same question needs to be continually asked as new regulations are promulgated. Just as many hospice providers have assumed that the requirement for "spiritual counseling and care" could be offered with quality by almost anyone, the new COPs seem to assume that quality professional social work can be offered by almost anyone with an undergraduate degree in any of the social sciences. One wonders if the next set of regulations may assume that good nursing care can be offered by anyone with basic first aid training. Certainly that would be less expensive. Perhaps we could then assume that the physician's role could be filled by paramedics, or EMTs, or former medics. The options are almost endless, if the only criteria are business decisions.

Policies and regulations are developed by all societies to express their underlying assumptions and their priorities about what (or who) is valued. It has been noted that the quality of any society may best be measured by how it values its most vulnerable citizens. The hospice movement came into being because some folks (nurses, social workers, chaplains, aides, physicians and volunteers) believed that those with terminal conditions deserved the best care possible. Many of us were first attracted to hospice by that ideal, and pursuit of that ideal was what enabled hospice care to be recognized as the "gold standard" in terms of pain and symptom relief, bereavement care, and many other aspects of end-of-life care.

While change and development may be inevitable; not all change is positive. Every hospice provider either seeks to maintain the values and ideals of the original vision, amidst changing conditions; or cheapens and "whittles away" at something which has been a blessing in the lives of so many. Only we in the hospice community can uphold those standards of humanity and compassion which brought hospice into being. Otherwise, it could easily become an empty shell, serving providers much better than patients. There is food for thought.

Did You Know?

NHPCO has Tip Sheets available for its members on the NHPCO web site. These sheets are discipline specific and relate to the newly revised CoPs. Check it out at **www.NHPCO.org**

Note: You must be an NHPCO member to log in.

The Leslie Lancon Memorial Education Nursing Scholarship was established in 2005 by LMHPCO. The annual scholarship will be awarded to support hospice nursing excellence and education throughout Lousisiana and Mississippi. The awards will focus not only on excellence for those seeking academic degrees in hospice nursing, but also those seeking advanced certification in hospice and palliative care nursing.

Donations may be sent payable to LMHPCO, 717 Kerlerec • New Orleans, LA 70116

Hospice Social Workers crosswalk

LA State Minimum Standards

Current as of December, 1999
Proposed Changes in Red

Subchapter A. General Provisions
§8201. Definitions
Core Services— nursing services, physician services, medical social services, and counseling services, including bereavement counseling, dietary counseling, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family. These services must be provided by employees of the hospice, except that physician services and counseling services may be provided through contract.

Emotional Support— counseling provided to assist the person in coping with stress, grief, and loss.

Family— a group of two or more individuals related by ties of blood, legal status, or affection who consider themselves a family.

Informed Consent— a documented process in which information regarding the potential and actual benefit and risks of a given procedure or program of care is exchanged between provider and patient.

Interdisciplinary Group (IDG)— an interdisciplinary group or groups designated by the hospice, composed of representatives from all the core services. The IDG must include at least a doctor of medicine or osteopathy, a registered

Medicare Conditions of Participation (CoPs)

Revised June 5, 2008 with Effective Date of Revisions December 2, 2008

§ 418.3 Definitions.
Comprehensive assessment means a thorough evaluation of the patient's physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions. This includes a thorough evaluation of the caregiver's and family's willingness and capability to care for the patient.

Initial assessment means an evaluation of the patient's physical, psychosocial and emotional status related to the terminal illness and related conditions to determine the patient's immediate care and support needs.

Licensed professional means a person licensed to provide patient care services by the State in which services are delivered.

Representative means an individual who has the authority under State law (whether by statute or pursuant to an appointment by the courts of the State) to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill patient who is mentally or physically incapacitated. This may include a legal guardian.

Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

MS State Minimum Standards

Current as of February 22, 2008

101 DEFINITIONS
101.16 Core Services – Nursing services, physician services, medical social services, and counseling services, including bereavement counseling, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family. These services must be provided by employees of the hospice, except that physician services and counseling services may be provided through contract.

101.17 Counselor – Means an individual who has at least a bachelor's degree in psychology, a master's or bachelor's degree from a school of social work accredited by the Council on Social Work
Education, a bachelor's degree in counseling; or the documented equivalent of any of the above in education, training in the spiritual care of the dying and end of life issues, and who is currently licensed in the state of Mississippi, if applicable. Verification of education and training must be maintained in the individual's personnel file.

101.23 Emotional Support – Support provided to assist the person in coping with stress, grief and loss.

101.24 Family Unit – Means the terminally ill person and his or her family, which may include spouse, children,

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nurse, a social worker, and a pastoral or other counselor. The interdisciplinary group is responsible for participation in the establishment of the plan of care; provision or supervision of hospice care and services; periodic review and updating of the plan of care for each individual receiving hospice care, and establishment of policies governing the day-to-day provision of hospice care and services. If a hospice has more than one interdisciplinary group, it must designate in advance the group it chooses to execute the establishment of policies governing the day-to-day provision of hospice care and services.

Medical Social Services— include a comprehensive psychosocial assessment; ongoing support for the patient and family; and assistance with coping skills, anticipatory grief, and grief reactions.

Representative— an individual who has been authorized under State law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated.

*Terminally Il*l— a medical prognosis of limited expected survival, of approximately six months or less at the time of referral to a hospice, of an individual who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone are no longer appropriate.

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sibling, parents, and other with significant personal ties to the patient.

101.33 Informed Consent – A documented process in which information regarding the potential and actual benefits and risks of a given procedure or program of care is exchanged between provider and patient.

101.35 Interdisciplinary Team (IDT) – An interdisciplinary team or group(s) designated by the hospice, composed of representatives from all the core services. The Interdisciplinary Team must include at least a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor. The interdisciplinary team is responsible for participation in the establishment of the plan of care; provision or supervision of hospice care and services; periodic review and updating of the plan of care for each individual receiving hospice care, and establishment of policies governing the day-to-day provision of hospice care and services. If a hospice has more than one interdisciplinary team; it must designate, in advance, the team it chooses to execute the establishment of policies governing the day to- day provision of hospice care and services.

101.42 Medical Social Services – Include a comprehensive psychosocial assessment; ongoing support for the patient and family; and assistance with coping skills, anticipatory grief, and grief reactions.

101.55 Representative – An individual who has been authorized under State law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated.

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LA State Minimum Standards	Medicare Conditions of Participation (CoPs)	MS State Minimum Standards
		101.58 Social Worker – An individual who has a degree from a school of social work accredited by the Council on Social Work Education and is licensed by the State of Mississippi. ***101.61 Terminally Ill-*** A medical prognosis of limited expected survival of approximately six months or less, if the disease follows its normal course, of an individual who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone is no longer appropriate.
Subchapter B. Organization and Staffing **§8217. Personnel Qualifications/Responsibilities** J. Social Worker 1. Qualifications. A master's degree from a school of social work accredited by the Council on Social Work Education: 1. Qualifications. A master's degree from a school of social work accredited by the Council on Social Work Education, either credentialed GSW or licensed as a LCSW, with at least one year of health care experience: a. documented clinical experience appropriate to the counseling and casework needs of the terminally ill. b. must be an employee of the hospice; and b. obtain at least 2 hours of Continuing Education Units (CEU's) annually related to end of life care. c. must be an employee of the hospice; and c. when the Social Worker is employed by one or more agencies he/she must inform all employers and cooperate and coordinate duties to assure the highest	**§418.62 Condition of participation: Licensed professional services.** (a) 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. (b) 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 (c) Licensed professionals must participate in the hospice's quality assessment and performance improvement program and hospice sponsored in-service training. **§ 418.114 Condition of participation: Personnel qualifications.** ***(a) General qualification requirements.*** Except as specified in paragraph (c) of this section, all professionals who	**PART V POLICIES AND PROCEDURES** **111 PERSONNEL POLICIES** **111.04 Employee Health Screening** – Every employee of a hospice who comes in contact with patients shall receive a health screening by a licensed physician, nurse practitioner or employee health nurse who conduct exams prior to employment and annually thereafter. The employee health screening shall include, but not be limited to, tuberculosis screening. **111.05 Staffing Schedule** – Each hospice and alternate site shall maintain on site current staffing patterns for all health care personnel including full-time, part-time, contract staff and staff under arrangement. The staffing pattern shall be developed at least one week in advance, updated daily as needed, and kept on file for a period of one year. The staffing pattern shall indicate the following for each working day: 1. Name and position of each staff member. 2. Patients to be visited. 3. Scheduled on call after office hours.

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performance of quality when providing services to the patient.

2. Responsibilities. The social worker shall assist the physician and other IDG members in understanding significant social and emotional factors related to the patient's health status and shall include, but not be limited to:
2. Responsibilities. The social worker shall assist the IDT members in understanding significant social and emotional factors related to the patient's health status and shall include, but not be limited to:

a. assessment of the social and emotional factors having an impact on the patient's health status;
a. assessment of the psychological, social and emotional factors having an impact on the patient's health status;

b. assist in the formulation of the POC;

c. provide services within the scope of practice as defined by state law and in accordance with the POC;

d. coordination with other IDG members and participate in IDG conferences;
d. coordination with other IDT members and attend IDT conferences;

e. prepare clinical and/or progress notes and incorporate them into the clinical record within one week of the visit;
f. participate in discharge planning, and in-service programs related to the needs of the patient;
g. acts as a consultant to other members of the IDG; and
g. acts as a consultant to other members of the IDT; and
h. when medical social services are discontinued, submit a written summary of services provided, including an assess-

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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.
(b) Personnel qualifications for certain disciplines.
(3) Social worker. A person who—
(i)
(A) Has a Master of Social Work (MSW) degree from a school of social work accredited by the Council on Social Work Education; or
(B) Has a baccalaureate degree in social work from an institution accredited by the Council on Social Work
Education; or a baccalaureate degree in psychology, sociology, or other field related to social work and is supervised by an MSW as described in paragraph (b)(3)(i)(A) of this section; and
(ii) Has 1 year of social work experience in a healthcare setting; or
(iii) Has a baccalaureate degree from a school of social work accredited by the Council on Social Work Education, is employed by the hospice before December 2, 2008, and is not required to be supervised by an MSW.

§ 418.116 Condition of participation: Compliance with Federal, State, and local laws and regulations related to health and safety of patients.
(a) Standard: Licensure of staff. Any persons who provide hospice services must be licensed, certified, or registered in accordance with applicable Federal, State and local laws.

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113 ORGANIZATION AND STAFFING PERSONNEL QUALIFICATIONS/RESPONSIBILITIES

113.15 Social Worker
1. Qualifications – A minimum of a bachelor's degree from a school of social work accredited by the Council of Social Work Education. This individual must be licensed in the State of Mississippi.
a. A minimum of one year documented clinical experience appropriate to the counseling and casework needs of the terminally ill.

b. Must be an employee of the hospice.

2. Responsibilities – The social worker shall assist the physician and other IDT members in understanding significant social and emotional factors related to the
patient's health status and shall include, but not be limited to:

a. Assessment of the social and emotional factors having an impact on the patient's health status;

b. Assist in the formulation of the POC;

c. Provide services within the scope of practice as defined by state law and in accordance with the POC;

d. Coordination with other IDT members and participate in IDT conferences;

e. Prepare clinical and/or progress notes and incorporate them into the clinical record within one week of the visit;

f. Participate in discharge planning, and in-service programs related to the needs of the patient;

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ment of the patient's current status, to be retained in the clinical record.		g. Acts as a consultant to other member of the IDT; h. When medical social services are discontinued, submit a written summary of services provided, including an assessment of the patient's current status, to be retained in the clinical record; and i. Attend hospice IDT meetings.
§8221. Plan of Care (POC) A. Prior to providing care, a written plan of care is developed for each patient/family by the attending physician, the Medical Director or physician designee and the IDG. The care provided to an individual must be in accordance with the POC. 1. The initial plan of care (IOPC) will be established on the same day as the assessment if the day of assessment is to be a covered day of hospice. 2. The IDG member who assesses the patient's needs must meet or call at least one other IDG member before writing the IPOC. At least one of the persons involved in developing the IPOC must be a registered nurse or physician. Within 2 days of the assessment, the other members of the IDG must review the IPOC and provide their input. This input may be by telephone. The IPOC is signed by the attending physician and an appropriate member of the IDG. 3. At a minimum the POC will include the following: a. an assessment of the individual's needs and identification of services, including the management of discomfort and symptom relief; b. in detail, the scope and frequency of services needed to meet the patient's and family's needs; c. identification of problems with real-	**§ 418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services.** The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient. 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. **(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. 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	**114.02 Plan of Care (POC)** 1. Within 48 hours of the admission, a written plan of care must be developed for each patient/family by a minimum of two IDT members and approved by the full IDT and the Medical Director at the next meeting. The care provided to an individual must be in accordance with the POC. a. The IDT member who assesses the patient's needs must meet or call at least one other IDT member before writing the IPOC. At least one of the persons involved in developing the IPOC must be a registered nurse or physician. b. At a minimum the POC will include the following: 1. An assessment of the individual's needs and identification of services, including the management of discomfort and symptom relief; 2. In detail, the scope and frequency of services needed to meet the patient's and family's needs. The frequency of services established in the POC will be sufficient to effectively manage the terminal diagnosis of the patient, provide appropriate amounts of counseling to the family, and meet or exceed nationally accepted hospice standards of practice; 3. Identification of problems with realistic and achievable goals and objectives;

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istic and achievable goals and objectives;
d. medical supplies and appliances including drugs and biologicals needed for the palliation and management of the terminal illness and related conditions;
e. patient/family understanding, agreement and involvement with the POC; and
f. recognition of the patient/family's physiological, social, religious and cultural variables and values.
4. The POC is incorporated into the individual clinical record.
5. The hospice will designate a Registered Nurse to coordinate the implementation of the POC for each patient.

B. Review and Update of the Plan of Care. The plan of care is reviewed and updated at intervals specified in the POC, when the patient's condition changes, and a minimum of every 14 days for home care and every 7 days for general inpatient care, collaboratively with the IDG and the attending physician.
1. Agency shall have policy and procedures for the following:
a. the attending physician's participation in the development, revision, and approval of the POC is documented. This is evidenced by change in patient orders and documented communication between Hospice Staff and the attending physician;
b. physician orders must be signed and dated in a timely manner, not to exceed 14 days, unless the hospice has documentation that verifies attempts to get orders signed; in this situation up to 30 days will be allowed.
2. The agency shall have documentation that the patient's condition and POC is reviewed and the POC updated, even when the patient's condition does

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of the interdisciplinary plan of care. 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.
(iv) A pastoral or other counselor.
(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. 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.
(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:
(1) Interventions to manage pain and symptoms.
(2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family

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4. Medical supplies and appliances including drugs and biologicals needed for the palliation and management of the terminal
illness and related conditions;
5. Patient/family understanding, agreement and involvement with the POC; and
6. Recognition of the patient/family's physiological, social, religious and cultural variables and values.
c. The POC must be maintained on file as part of the individual's clinical record. Documentation of updates shall be maintained.

114.03 Review and Update of the Plan of Care
The plan of care is reviewed and updated at intervals specified in the POC, when the patient's condition changes and a minimum of every 14 days for home care and every 7 days for general inpatient care, collaboratively with the IDT and the attending physician.
2. The agency shall have documentation that the patient's condition and POC is reviewed and the POC updated, even when the patient's condition does not change.

114.04 Coordination and Continuity of Care
1. The hospice shall adhere to the following additional principles and responsibilities:
a. An assessment of the patient/family needs and desire for hospice services and a hospice program's specific admission, transfer, and discharge criteria determine any changes in services;
d. Case-management is provided and an accurate and complete documented record of services and
activities describing care of

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not change.

C. Coordination and Continuity of Care. The hospice shall adhere to the following additional principles and responsibilities:
1. an assessment of the patient/family needs and desire
for hospice services and a hospice program's specific
admission, transfer, and discharge criteria determine any changes in services;
4. case-management is provided and an accurate and complete documented record of services and activities describing care of patient/family is maintained;
16. each member of the IDG accepts a fiduciary relationship with the patient/family, maintaining professional boundaries and an understanding that it is the responsibility of the IDG to maintain appropriate
agency/patient/family relationships;

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needs.
(3) Measurable outcomes anticipated from implementing and coordinating the plan of care.
(4) Drugs and treatment necessary to meet the needs of the patient.
(5) Medical supplies and appliances necessary to meet the needs of the patient.
(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.
(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.
(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.
(2) Ensure that the care and services are provided in accordance with the plan of care.
(3) Ensure that the care and services provided are based on all assessments of the patient and family needs.
(4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and serv-

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patient/family is maintained;
i. When home care is no longer possible, assistance to the patient in transferring to an appropriate setting where hospice care can be delivered;
k. Maintenance of appropriately qualified IDT health care professionals and volunteers to
meet patients need;
m. Coordination of the IDT, as well as of volunteers, by a qualified health care professional, to assure continuous assessment, continuity of care and implementation of the POC;
n. Supervision and professional consultation by qualified personnel, available to staff and volunteers
during all hours of service;
o. Hospice care provided in accordance with accepted
professional standards and accepted code of ethics;
p. The facility must proceed in accordance with written policy at the time of death of the patient.

NOTE: The Crosswalk is not all inclusive of all standards. Providers are urged to make certain they have a current copy of the CoPs as well as the State Minimum Standards.

LA State Minimum Standards	Medicare Conditions of Participation (CoPs)	MS State Minimum Standards
	ices are provided directly or under arrangement. (5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.	
§8201 **Core Services**— nursing services, physician services, medical social services, and counseling services, including bereavement counseling, dietary counseling, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family. These services must be provided by employees of the hospice, except that physician services and counseling services may be provided through contract.	**Core Services** **§ 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. **(c) Standard: Medical social services.** Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services.	**PART VI BASIC HOSPICE CARE** **116 CORE SERVICES** 116.01 Hospice care shall be provided by a hospice care team. Medical, nursing and counseling services are basic to hospice care and shall be provided directly (Medical Director only may be contract). Hospice care will be available twenty-four (24) hours a day, seven (7) days a week. 4. Social services shall be directed by a social worker, and shall consist primarily of assisting the patient and family unit to deal with problems of social functioning affecting the health or well-being of the patient.
§8233. Clinical Records A. In accordance with accepted principles of practice the hospice shall establish and maintain a clinical record for every individual receiving care and services. The record shall be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. The clinical record shall contain all pertinent past and current medical, nursing, social, and other therapeutic information, including the current POC under which services are being delivered. H. The clinical record shall contain a comprehensive compilation of informa-	**§ 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. **(a) Standard: Content.** Each patient's record must include the following: (1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical	**114.10 Clinical Records** 1. In accordance with accepted principles of practice the hospice shall establish and maintain a clinical record for every individual receiving care and services. The record shall be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. The clinical record shall contain all pertinent past and current medical, nursing, social and other therapeutic information, including the current POC under which services are being delivered. 8. The clinical record shall contain a comprehensive compilation of informa-

NOTE: The Crosswalk is not all inclusive of all standards. Providers are urged to make certain they have a current copy of the CoPs as well as the State Minimum Standards.

LA State Minimum Standards

tion including, but not limited to, the following:
1. initial and subsequent Plans of Care and initial assessment;
2. certifications of terminal illness;
3. written physician's orders for admission and changes to the POC;
4. current clinical notes (at least the past sixty (60) days);
5. Plan of Care;
6. signed consent, authorization and election forms;
7. pertinent medical history; and
8. identifying data, including name, address, date of birth, sex, agency case number; and next of kin.
I. Entries are made for all services provided and are signed by the staff providing the service.
J. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.) are recorded whether furnished directly by hospice staff or by arrangement.

Medicare Conditions of Participation (CoPs)

notes.
(2) Signed copies of the notice of patient rights in accordance with § 418.52 and election statement in accordance with § 418.24.
(3) Responses to medications, symptom management, treatments, and services.
(4) Outcome measure data elements, as described in § 418.54(e) of this subpart.
(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.
(6) Any advance directives as described in § 418.52(a)(2).
(7) Physician orders.

MS State Minimum Standards

tion including, but not limited to, the following:
a. Initial and subsequent Plans of Care and initial assessment;
b. Certifications of terminal illness;
c. Written physician's orders for admission and changes to the POC;
d. Current clinical notes (at least the past sixty (60) days;
e. Plan of Care;
f. Signed consent, authorization and election forms;
g. Pertinent medical history; and
h. Identifying data, including name, address, date of birth, sex, agency case number and next of kin.
9. Entries for all provided services must be documented in the clinical record and must be signed by the staff providing the service.
10. Complete documentation of all services and event (including evaluations, treatments, progress notes, etc.) are recorded whether furnished directly by hospice staff or by arrangement.

122 RECORDS
122.02 Content - Each clinical record shall be comprehensive compilation of information. Entries shall be made for all services provided and shall be signed and dated within 7 days by the individual providing the services. The record shall include all services whether furnished directly or under arrangements made by the hospice. Each patient's record shall contain:
1. Identification data;
2. The initial and subsequent assessments;
3. The plan of care;
4. Consent and authorization forms;
5. Pertinent medical and psychosocial history;
6. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.)

NOTE: The Crosswalk is not all inclusive of all standards. Providers are urged to make certain they have a current copy of the CoPs as well as the State Minimum Standards.

LA State Minimum Standards

§8239. Quality Assurance

A. Agency shall have an on-going, comprehensive, integrated, self-assessment quality improvement process which provides assurance that patient care, including inpatient care, home care, and care provided by arrangement, is provided at all times in compliance with accepted standards of professional practice.

D. Hospice follows a written plan for continually assessing and improving all aspects of operations which include:

4. the method for evaluating the quality and the appropriateness of care;

5. a method for resolving identified problems; and

6. application to improving the quality of patient care.

G. Quality assessment and improvement activities are based on the systematic collection, review, and evaluation of data which, at a minimum, includes:

1. services provided by professional and volunteer staff;

2. outcome audits of patient charts;

3. reports from staff, volunteers, and clients about services;

4. concerns or suggestions for improvement in services;

5. organizational review of the hospice program;

6. patient/family evaluations of care; and

7. high-risk, high-volume and problem-prone activities.

Medicare Conditions of Participation (CoPs)

§ 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. 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.

(c) Standard: Program activities.

(1) The hospice's performance improvement activities must:

(i) Focus on high risk, high volume, or problem-prone areas.

(ii) Consider incidence, prevalence, and severity of problems in those areas.

(iii) Affect palliative outcomes, patient safety, and quality of care.

(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.

(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.

(d) Standard: Performance improvement projects. Beginning February 2, 2009 hospices must develop, implement, and evaluate performance improvement projects.

MS State Minimum Standards

115.05 Quality Assurance

115.05 Quality Assurance

1. The hospice shall conduct an ongoing, comprehensive

integrated self-assessment quality improvement process (inclusive of inpatient care, home care and respite care) which evaluates not only the quality of care provided, but also the appropriateness care/services provided and evaluations of such services. Findings shall be documented and used by the hospice to correct identified problems and

to revise hospice policies.

5. The Hospice's written plan for continually assessing and improving all aspects of operations must include:

b. A system to ensure systematic, objective quarterly reports. Documentation must be maintained to reflect that such reports were reviewed with the IDT, the Medical Director, the Governing Body and distributed to appropriate areas;

6. Quality assessment and improvement activities are based on the systematic collection, review, and evaluation of data which, at a minimum, includes:

a. Services provided by professional and volunteer staff;

b. Outcome audits of patient charts;

c. Reports from staff, volunteers, and clients about services;

d. Concerns or suggestion for improvement in services;

e. Organizational review of the hospice program;

f. Patient/family evaluations of care; and

g. High-risk, high-volume and problem-prone activities.

7. The quality improvement plan must be reviewed at least annually and revised as appropriate.

121 IN-SERVICE TRAINING

121.01 The hospice shall provide ongoing, relevant in-service training for all

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LA State Minimum Standards	Medicare Conditions of Participation (CoPs)	MS State Minimum Standards
		members of the hospice care team. 121.02 For each direct-care employee, the hospice shall require training of twelve (12) hours inservice education, at a minimum annually. Documentation of such training shall be maintained.

NOTE: The Crosswalk is not all inclusive of all standards. Providers are urged to make certain they have a current copy of the CoPs as well as the State Minimum Standards.

Calendar

February 4, 2009
Area Code 225 Quarterly Luncheon
For more info, contact Stephanie Schedler at sschedler@glendalehc.com

February 11-13, 2009
Hospice Administrator's Certification Program (HACP)
New Orleans, LA
For more information, go to:
http://www.lmhpco.org/blahdocs/uploads/hacpfebbrochurerevised_1051.pdf

February 18, 2009
Area Codes 504/985 Quarterly Luncheon
For more information, contact Opal Carriere at opal@serenityhospice.com

February 20, 2009
Area Code 318 Quarterly Luncheon
For more information, contact Martha McDurmond at hosbmcm@bellsouth.net

March 5, 2009
Area Code 337 Quarterly Luncheon
For more information, contact Kathleen Guidry at kathleen.guidry@lhcgroup.com

March 25-28, 2009
AAHPM & HPNA Annual Assembly
Austin, TX
For more information go to:
http://www.hpna.org/DisplayPage.aspx?Title=Annual%20Conferences

March 26-27, 2009
National Association of Social Workers, Mississippi Chapter Annual Conference, Natchez, MS
"Social Work 2009: Defining Purpose and Exploring Possibilities"
For more information and on-line Registration, go to http://www.naswm-schapter.org/conferenceinfo.htm

April 16, 2009
Area Code 662 Quarterly Luncheon
For more information contact Nancy Dunn at nancy@LMHPCO.org

April 23-25, 2009
NHPCO's 24th Management & Leadership Conference
Omni-Shoreham Hotel, Washington, DC
For more information go to:
http://www.nhpco.org/i4a/pages/index.cfm?pageid=3259

April 29, 2009
16th Annual National HFA Living with Grief Teleconference (12:30-3:00PM)
Diversity & End-of-Life Care
For more information, go to:
www.hospicefoundation.org

July 29-30, 2009
(Wednesday & Thursday)
LMHPCO Annual Leadership Conference & Annual Meeting
Loews Hotel, New Orleans, LA

July 31, 2009
(Friday)
LMHPCO Annual Leadership Post-Conference
Loews Hotel, New Orleans, LA

September 24-26, 2009
NHPCO's 10th Clinical Team Conference
Hyatt Regency, Denver, CO
For more information go to:
http://www.nhpco.org/i4a/pages/index.cfm?pageid=3259

December 4-6, 2009
NHPCO's 6th National Conference on Volunteerism & Family Caregiving
Walt Disney Swan Hotel, Orlando, FL
For more information go to:
http://www.nhpco.org/i4a/pages/index.cfm?pageid=3259

briefs

Attendees at the 662 meeting listen attentively as Randy Ponder discusses MS Medicaid Billing.

Randy Ponder with ACS discusses MS Medicaid billing at the 662 meeting in Oxford, MS.

Randy Ponder will present this material in Jackson and Gulfport at the April (dates to be determined) Quarterly Area Code meetings and Marilyn Winborne and Steve Eggers with MSDH will discuss MS Surveys and Deficiencies in Oxford on April 16.

Nancy Dunn, LMHPCO Education Director, presented a 2 hour in-service on "The Central Needs of the Mourner" for the MS Chaplains Association meeting on January 8, 2009 with 75 chaplains in attendance.

Kathryn Delcambre (QAPI Coordinator for Hospice of Acadiana) continues to help LMHPCO members understand the new CoP requirements regarding QAPI. She is presenting at the Louisiana Area Code meetings in Baton Rouge, New Orleans, and Jennings throughout February. LMHPCO is grateful to Hospice Acadiana for loaning our membership their resident QA/PI expert. The new QA/PI requirements went into effect on February 2, 2009.

SAVE THE DATE

MISSION POSSIBLE
CERTAINTY IN UNCERTAIN TIMES

Annual Leadership Conference
July 29-31, 2009
Loews New Orleans Hotel

Heart of Hospice Award Nominations Requested

LMHPCO is seeking nominations for the Annual Heart of Hospice Award. This award recognizes an individual who has attained repeated outstanding achievements in hospice and end-of-life care. Award presentations will be held on Thursday, July 30, 2009, at the lunch meeting of the LMHPCO Annual Leadership Conference in New Orleans.

Enter your submission today!

Download form at: http://www.lmhpco.org/blahdocs/uploads/2009 hoh award nomination form 5630.doc

LMHPCO Heart of Hospice Award 2009 Nomination Form

Deadline for Nomination is Monday, June 1, 2009

The Heart of Hospice Award recognizes an individual from each of the two states who has attained repeated outstanding achievements in hospice and end-of-life care. This award will be presented on Thursday, July 30, 2009 at the Lunch Meeting of the LMHPCO Annual Leadership Conference in New Orleans.

Information requested includes all of the following:

Name of **Nominee**
Hospice/Palliative Care Program Affiliation:
City: State: Zip:
Phone number: Fax:
E-mail address:
Nominee's Curriculum Vitae/Resume

Narrative: Describe nominee's history and relationship to hospice/palliative care, including accomplishments and contributions to hospice/palliative care.

Reference Letters (at least 1)

Name of **Nominator** (Your Name):
Hospice/Palliative Care Program Affiliation:
City: State: Zip:
Phone number: Fax:
E-mail address:

All requested materials may be e-mailed or mailed by June 1, 2009 to:
E-mail: nancy@LMHPCO.org
Mail: LMHPCO • 717 Kerlerec • New Orleans, LA 70116

Members make the work of LMHPCO possible!

(2009 memberships received as of 2/5/2009)

PROVIDER MEMBERS:

AseraCare Hospice, Corinth, MS
AseraCare Hospice, Flowood, MS
AseraCare Hospice, Philadelphia, MS
AseraCare Hospice, Senatobia, MS
AseraCare Hospice, Starkville, MS
AseraCare Hospice, Tupelo, MS
Bayou Region Hospice, Houma, LA
Circle of life Hospice, Inc, Shreveport, MS
Christus Schumpert Community Hospice, Shreveport, LA
Community Hospice of America, McComb, MS
Community Hospice of America, Meridian, MS
Community Hospice of America, Natchez, MS
Community Hospice of America, Shreveport, LA
Continue Care Hospice, Hollandale, MS
Crossroads Hospice, LLC, Delhi, LA
Destiny Hospice Palliative care & Specialty Services, Inc, Tutwiler, MS
Elayn Hunt Correctional Center, St Gabriel, LA
Eternity Hospice, Inc, Gulfport, MS
Eternity Hospice, Inc, Indianola, MS
Eternity Hospice, Inc, Laurel, MS
First Choice Hospice, Inc, Olla, LA
Gulf Coast Hospice, Ocean Springs, MS
Hospice Associates, Metairie, LA
Hospice Care of Louisiana, Alexandria, LA
Hospice Care of Louisiana, Baton Rouge, LA
Hospice Care of Louisiana, Lafayette, LA
Hospice Care of Louisiana, Monroe, LA
Hospice Care of Louisiana, New Orleans, LA
Hospice Care of Louisiana, Slidell, LA
Hospice Care of Mississippi, Waveland, MS
Hospice In His Care, Baton Rouge, LA
Hospice in His Hands, Carthage, MS
Hospice in His Hands, Kosciusko, MS
Hospice in His Hands, Magee, MS
Hospice in His Hands, Walnut Grove, MS
Hospice Ministries, Brookhaven, MS
Hospice Ministries, McComb, MS
Hospice Ministries, Natchez, MS
Hospice Ministries, Ridgeland, MS
Hospice of Acadiana, Lafayette, LA
Hospice of Baton Rouge, Baton Rouge, LA
Hospice of Light, Gautier, MS
Hospice of Light, Lucedale, MS
Hospice of Caring Hearts, LLC, Dubach, LA
Hospice of Shreveport/Bossier, LA
Jordan's Crossing Hospice, LLC, Shreveport, LA
Life Source Services, LLC, Baton Rouge, LA
Livingston Hospice Associates, LLC, Walker, LA
Louisiana Hospice, Mamou, LA
Louisiana Hospice & Palliative Care, Jennings, LA
Louisiana State Penitentiary Hospice, Angola, LA
Magnolia Regional Health Center Home Health & Hospice Agency, Corinth, MS
Mid Delta Hospice, Batesville, MS
My Hospice, Metairie, LA
North Mississippi Medical Center, Tupelo, MS
Odyssey Healthcare, Jackson, MS
Odyssey Healthcare of the Gulf Coast, Gulfport, MS
Odyssey Healthcare of Lake Charles, LA
Odyssey Healthcare of NW Louisiana, Shreveport, LA
Pax Hospice, Madison, MS
Pointe Coupee Hospice, New Roads, LA
Premier Hospice, LLC, Bastrop, LA
River Region Hospice, LLC, River Ridge, LA
River Region Hospice House, River Ridge, LA
St Joseph Hospice Bayou Region, Thibodaux, LA
St Joseph Hospice CenLa, LLC, Alexandria, LA
St Joseph Hospice & Palliative Care Northshore, Covington, LA
St Joseph Hospice of Acadiana, LLC Lafayette, LA
St Joseph Hospice of Shreveport, LLC, Shreveport, LA
St Theresa's Hospice & Pallaitive Care, Lafayette, LA
Serenity Hospice Services, New Orleans, LA
Truecare Hospice, Raymond, MS
Vital Hospice, Inc, Hammond, LA

ASSOCIATE MEMBERS

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Leonard J Chabert Medical Center, Houma, LA
HealthCare ConsultLink, Ft Worth, TX
MUMMS Software, New Orleans, LA
ProCare Hospice Care, Duluth, GA

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Palliative Care Institute of Southeast Louisiana, Covington, LA

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Patricia Andrews, New Orleans, LA
Susan Drongowski, Las Vegas, NV
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Heather Liao, RN, Madison, MS
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PALLIATIVE CARE MEMBERS

Our Lady of the Lake RMC, Baton Rouge, LA

Hospice Administrator Certificate Program (HACP)

February 11-13, 2009 – New Orleans, LA - Hotel Monteleone

Brought to you by: CAHSAH, TCG, NAHC
Co-sponsored by: LMHPCO
Supported by: HospiScript

The goal of the Hospice Administrator Certificate Program (HACP) is to provide a supportive learning environment for administrators and senior managers. The HACP will strengthen your competencies to position your organization for success and help you integrate the complexities of quality, compliance, financial management, and strategic performance. The HACP is broken down into a three module curriculum. Each participant will receive a comprehensive manual that is a must-have resource for years to come.

PROGRAM GOALS:

- Identify key health care trends that will influence positioning strategies of your hospice organization
- Integrate data management and analysis methods into your quality assessments and performance improvement program
- Implement key financial management strategies to prepare and interpret financial documents and to understand the impact of current changes in health care
- Understand leadership responsibilities in promoting a quality driven organization
- Integrate corporate compliance issues with clinical, financial and legal integrity of the organization

Registration brochure available at:
http://www.lmhpco.org/blahdocs/uploads/hacpfebbrochurerevised_1051.pdf