March 2009

in this issue
Hospice Aides

The Journal

Talent, Care & Compassion at Its Best

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Hospice Aides are some of the most talented, caring and compassionate people you will ever meet. They play a significant role in the Interdisciplinary Team as they care for hospice patients and their families.

Hospice aides are typically the members of the IDT who spend the most time with the patient. They provide for the personal care and assist with ADLs. Hospice Aides are the "eyes and ears" for the RN as they report changes in the patient's condition. Oftentimes, a patient will be more open and responsive and share things with the Hospice Aide that they will not share with any other member of the IDT. The rapport that is established never ceases to amaze me.

The newly revised Conditions of Participation (CoPs) replaced the Home Health Aide language with Hospice Aide. Hospice Aides must demonstrate expertise and competency in End-of-life care. Some of the areas that must be included in hospice aide training include communication skills; observation, reporting and documentation skills; recording of TPR; basic infection control measures; basic elements of body functioning and changes to be reported; maintaining a clean, safe environment; physical, emotional and developmental needs of the hospice population; safe techniques in performing Activities of Daily Living (ADLs); transfer techniques; range of motion; and nutritional intake (418.76).

Surveyors will be looking for documentation of the training received, skills taught and competency verification. Hospices are required to fulfill 12 hours of in-service training within a 12 month period for Hospice Aides.

The RN is responsible for supervision of the Hospice Aide. Surveyors will be assessing agencies to see that written instructions are prepared and the aide is receiving supervision. Providers are held to the most stringent guidelines, whether state or federal.

The LA Minimum Standards dictate the "RN is to perform supervisory visits to the patient's residence at least every 14 days to assess relationships and determine whether goals are being met. A supervisory visit with the aide present must be made at least once every three (3) months" (8217 O 2(i)).

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LOUISIANA~MISSISSIPPI
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next month: Hospice Volunteers with Crosswalk of Newly Revised CoPs

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HOSPICE AND PALLIATIVE CARE ORGANIZATION

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.

The Journal is produced monthly by Noya Design, Inc. Newsworthy submissions are encouraged. Please contact Glenn Noya with questions, comments and submissions at ph: 504-455-2585 • Em: noyadesign@cavtel.net

BEST – *continued from page one*

The MS Minimum Standards require the "RN to make supervisory visits to the patient's residence at least every other week with the aide alternately present and absent, to provide direct supervision, to assess relationships and determine whether goals are being met. For the initial visit, the RN must accompany/assist the nurse aide" (113.14 2 h).

The CoPs require "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.

(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.

(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 in accordance with § 418.76(c).

(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." § 418.76 (h)

Providers are strongly encouraged to review the Minimum Standards for their respective state(s) as well as the newly revised CoPs.

LMHPCO is committed to providing quality educational in-services to our Hospice Aides. This will be accomplished through Area Code Meetings. The content will be hospice specific and pertain to the Hospice Aides and End-of-life Care. Watch the Weekly Updates for forthcoming information.

We salute our Hospice Aides!

Did You Know?

March is **National Social Work Month**. A special thanks to our Hospice Social Workers throughout LA and MS for the care and compassion given to hospice patients and families.

At the recent Mississippi Area Code 601 & 228 quarterly meetings, MSDH's Marilynn Winborne advised members to review the Vulnerable Adult Act of 1986 and referred to sections 43-47-5 (definitions -- referencing care facility/hospice) and 43-47-37 (reporting of abuse and exploitation of patients and residents of care facilities). The law is located at:
http://www.mscode.com/free/statutes/43/047/index.htm

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 AIDES crosswalk

LA State Minimum Standards

Current as of December, 1999
Proposed Changes in Red

Subchapter A. General Provisions
§8201. Definitions
Activities of Daily Living (ADL's) — Subchapter A. General Provisions §8201. Definitions Activities of Daily Living (ADL's)— the following functions or tasks performed either independently or with supervision or assistance:
a. mobility;
b. transferring;
c. walking;
d. grooming;
e. bathing;
f. dressing and undressing;
g. eating; and
h. toileting.

Homemaker— an individual who provides light housekeeping services to patients in their homes.

Non Core Services— services provided directly by hospice employees or under arrangement. These services include, but are not limited to:
a. home health aide and homemaker;
b. physical therapy services;
c. occupational therapy services;
d. speech-language pathology services;
e. inpatient care for pain control and symptom management and respite purposes; and
f. medical supplies and appliances including drugs and biologicals.

Medicare Conditions of Participation (CoPs)

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

§ 418.3 Definitions.
Clinical note means a notation of a contact with the patient and/or the family that is written and dated by any person providing services and that describes signs and symptoms, treatments and medications administered, including the patient's reaction and/or response, and any changes in physical, emotional, psychosocial or spiritual condition during a given period of time.

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
101.15 Contracted Services – Services provided to a hospice provider or its patients by a third party under a legally binding agreement that defines the roles and responsibilities of the hospice and service provider.

101.28 Hospice Aide – An individual who is currently qualified in the State of Mississippi to provide personal care services to hospice patients under the direction of a registered nurse of the hospice.

101.43 Non-Core Services – Services provided directly by hospice employees or under arrangement that are not considered Core Services. These services include, but are not limited to:
a. Hospice aide and homemaker
b. Physical therapy services
c. Occupational therapy services
d. Speech-language pathology services
e. General inpatient care
f. Respite care
g. Medical supplies and appliances including drugs and biologicals.

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.

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
Terminally Ill — 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.		
Subchapter B. Organization and Staffing **§8217. Personnel Qualifications/Responsibilities** G. Home Health Aide/Homemaker. (Hospice Aide/Homemaker): A qualified person who provides direct patient care and/or housekeeping duties in the home or homelike setting under the direct supervision of a registered nurse. 1. Qualifications. The home health aide/homemaker (hospice aide/homemaker) must meet one of the training requirements listed in §8217.F.a, b, and c and meet all other requirements: a. have current nursing assistant certification and have successfully completed a Home Health Aide (Hospice Aide) competency evaluation; or b. have successfully completed a Home Health Aide (Hospice Aide) training program and have successfully completed a competency evaluation; or c. have current CHPNA (Certified Hospice & Palliative Nursing Assistant) Certification and have successfully completed a competency evaluation, or c. (d) have successfully completed a Home Health Aide (Hospice Aide) competency evaluation; and d. (e) exhibit maturity, a sympathetic attitude toward the patient, ability to provide care to the terminal patient, and ability to deal effectively with the demands of the job; e. (f) have the ability to read, write, and carry out directions promptly and	**§ 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. ***(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 that meets the requirements of paragraphs (b) and (c) of this section. (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	**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. **113 ORGANIZATION AND STAFFING PERSONNEL QUALIFICATIONS/RESPONSIBILITIES** **113.07 Hospice Aide** A qualified person who provides direct patient care and/or housekeeping duties in the home or homelike setting under the direct supervision of a registered

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accurately; and
f. (g) when employed by more than one agency, inform all employers and coordinate duties to assure highest quality when providing services to the patients.
NOTE: The Home Health Aide (Hospice Aide) competency evaluation is to be completed by a registered nurse prior to the Home Health Aide (Hospice Aide) being assigned to provide patient care and annually.
2. Responsibilities. The home health aide/homemaker (Hospice Aide) shall provide personal care and support services established and delegated in POC, record and notify the primary registered nurse of deviations according to standard practice including, but not limited to, the following:
a. perform simple one-step wound care if written documentation of in-service and competency for that specific procedure is in the aide's personnel record. All procedures performed by the aide must be in compliance with current standards of nursing practice;
b. provide assistance with mobility, transferring,
walking, grooming, bathing, dressing or undressing, eating, toileting, and/or housekeeping needs. Some examples of assistance include:
i. helping the patient with a bath, care of the mouth,
skin and hair;
ii. helping the patient to the bathroom or in using a bed pan or urinal;
iii. helping the patient to dress and/or undress;
iv. helping the patient in and out of bed, assisting with ambulating;
v. helping the patient with prescribed exercises which the patient and home health aide (hospice aide) have been taught by appropriate personnel; and
vi. performing such incidental household services essential to the patient's health care at home that are necessary to prevent or postpone institutionaliza-

Medicare Conditions of Participation (CoPs)

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 24-month lapse in furnishing services, the individual must complete another program, as specified in paragraph (a)(1) of this section, before providing services.
(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.
(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.
(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.

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nurse. The facility shall ensure that each hospice aide is appropriately trained and competent to meet the needs of the patient per the plan of care. Documentation must be maintained on-site of all training and competency in accordance with patient plan of care.
1. Responsibilities – The hospice aide shall provide services established and delegated in POC, record and notify the primary registered nurse of deviations according to standard of practice including, but not limited to, the following:
a. Provide assistance with mobility, transferring, walking, grooming, bathing, dressing or undressing, eating, toileting, and/or housekeeping needs.
b. Complete a clinical note for each visit, which must be incorporated into the record at least on a weekly basis.
2. Restrictions – The hospice aide shall not:
a. Perform any intravenous procedures, procedures involving the use of Levine tubes or Foley
catheters, or any other sterile or invasive procedures.
b. Administer medications.
3. Initial Orientation – The content of the basic orientation provided to the hospice aides shall include the following:
a. Policies and objectives of the agency;
b. Duties and responsibilities of a hospice aide;
c. The role of the hospice aide as a member of the healthcare team;
d. Emotional problems associated with terminal illness;
e. The aging process;
f. Information on the process of aging and behavior of the aged;
g. Information on the emotional problems accompanying terminal illness;
h. Information on terminal care, stages of death and dying, and grief;

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tion;
d. complete a clinical note for each visit, which must be incorporated into the record at least on a weekly basis.
3. Restrictions. The home health aide/homemaker (hospice aide/homemaker) shall not:
a. perform any intravenous procedures, procedures
involving the use of Levine tubes or Foley catheters, or any
other sterile or invasive procedures, other than rectal
temperatures or enemas;
b. administer medications to any patient.
4. Initial Orientation. The content of the basic orientation provided to home health aides (hospice aides) shall include the following:
a. policies and objectives of the agency;
b. duties and responsibilities of a home health aide/homemaker (hospice aide/homemaker);
c. the role of the home health aide/homemaker (hospice aide/homemaker) as a member of the health care team;
d. emotional problems associated with terminal illness;
e. the aging process;
f. information on the process of aging and behavior of the aged;
g. information on the emotional problems accompanying terminal illness;
h. information on terminal care, stages of death and dying, and grief;
i. principles and practices of maintaining a clean, healthy and safe environment;
j. ethics; and
k. confidentiality
and
l. patients rights and responsibilities.
NOTE: The orientation and training curricula for home health aides/homemakers (hospice aides/homemakers) shall be detailed in a policies and procedures manual

Medicare Conditions of Participation (CoPs)

(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.
(4) The hospice must maintain documentation that demonstrates that the requirements of this standard are met.
(c) Standard: Competency evaluation.
An individual may furnish hospice aide services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in this section.
(1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (b)(3)(iii), (b)(3)(ix), (b)(3)(x) and (b)(3)(xi) of this section must be evaluated by observing an aide's performance of the task with a patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a

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i. Principles and practices of maintaining a clean, healthy and safe environment;
j. Ethics; and
k. Confidentiality.
NOTE: The orientation and training curricula for hospice aides shall be detailed in a policies and procedures manual maintained by the hospice agency and provision of orientation and training shall be documented in the employee personnel record.
4. Training shall include the following areas of instruction:
a. Assisting patients to achieve optimal activities of daily living;
b. Principles of nutrition and meal preparation;
c. Record keeping;
d. Procedures for maintaining a clean, healthful environment; and
e. Changes in the patients' condition to be reported to the supervisor.
5. In-service Training – The hospice aide must have a minimum of 12 hours of appropriate in-service training annually. In-service training may be prorated for employees working a portion of the year. However, part-time employee who worked throughout the year must attend all twelve (12) hours of in-service training.

113.14 Registered Nurse (RN)
The hospice must designate a registered nurse to coordinate the implementation of the POC for each patient.
2. Responsibilities – The registered nurse shall identify the patient/family's physical, psychosocial, and environmental
needs and reassess as needed but no less than every 14 days:
h. Make supervisory visits to the patient's residence at least every other week with the aide alternately present and absent, to provide direct supervision, to assess relationships and determine whether goals are being met.

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maintained by the hospice agency and provision of orientation and training shall be documented in the employee personnel record.
5. Initial Training shall include the following areas of instruction:
a. assisting patients to achieve optimal activities of daily living;
b. principles of nutrition and meal preparation;
c. record keeping;
d. procedures for maintaining a clean, healthful environment; and
e. changes in the patients' condition to be reported to the supervisor.
6. In-service Training. Home Health Aide/homemaker (Hospice Aide/homemaker) must have a minimum of 12 hours of appropriate in-service training specific to their job responsibilities within the previous 12 months (at least 2 hours must focus on end of life education). ~~annually. Six of these hours of in-service training must be provided each six months.~~ In-service training may be prorated for employees working a portion of the year. However, part-time employees who worked throughout the year must attend all twelve hours of in-service training. The in-service may be furnished while the aide is providing service to the patient, but must be documented as training.

O. Registered Nurse (RN). The hospice must designate a registered nurse to coordinate the implementation of the POC for each patient.
2. Responsibilities. The registered nurse shall identify the patient/family's physical, psychosocial, and environmental needs and reassess as needed but no less than every 14 days:
g. if a home health aide/homemaker (hospice aide/homemaker) is assigned to a patient by the RN, in accordance with the POC, specific written instructions for patient care are to be prepared

Medicare Conditions of Participation (CoPs)

hospice aide with a patient.
(2) A hospice aide competency evaluation program may be offered by any organization, except as described in paragraph (f) of this section.
(3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate.
(4) A hospice aide is not considered competent in any task for which he or she is evaluated as unsatisfactory. An aide must not perform that task without direct supervision by a registered nurse until after he or she has received training in the task for which he or she was evaluated as "unsatisfactory," and successfully completes a subsequent evaluation. A hospice aide is not considered to have successfully completed a competency evaluation if the aide has an "unsatisfactory" rating in more than one of the required areas.
(5) The hospice must maintain documentation that demonstrates the requirements of this standard are being met.
(d) Standard: In-service training. A hospice aide must receive at least 12 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient.
(1) In-service training may be offered by any organization, and must be supervised by a registered nurse.
(2) The hospice must maintain documentation that demonstrates the requirements of this standard are met.
(e) Standard: Qualifications for instructors conducting classroom and supervised practical training.
Classroom and supervised practical training must be performed by a registered nurse who possesses a minimum of 2 years nursing experience, at least 1 year of which must be in home care, or by other individuals under the general supervision of a registered nurse.

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For the initial visit, the RN must accompany/assist the nurse aide;
i. If a hospice aide is assigned to a patient by the RN, in accordance with the POC, specific written instructions for patient care are to be prepared by the RN. All personal care services are to be outlined for the patient, in writing, by the RN;
j. Document supervision, to include the hospice aide relationships, services provided and instructions and comments given as well as other requirements of the clinical note;
k. Document annual performance reviews for the hospice aide. This performance review must be maintained in the individual's personnel record;

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by the RN. All personal care services are to be outlined for the patient, in writing, by the RN in charge of that patient;
h. supervise and evaluate the home health aide/homemaker's (hospice aide/homemaker's) ability to perform assigned duties, to relate to the patient and to work effectively as a member of the health care team;
i. perform supervisory visits to the patient's residence at least every 14 days to assess relationships and determine whether goals are being met. A supervisory visit with the aide present must be made at least once every three (3) months;
j. document supervision, to include the aide/homemaker- (hospice aide/homemaker) patient relationships, services provided and instructions and comments given as well as other requirements of the clinical note; and
k. annual performance review for each aide/homemaker documented in the individual's personnel record.

Medicare Conditions of Participation (CoPs)

(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 of compliance with the requirements of § 484.36(a) and (b) of this chapter.
(2) Permitted an individual that does not meet the definition of a "qualified home health aide" as specified in § 484.36(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 govern-

MS State Minimum Standards

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LA State Minimum Standards	Medicare Conditions of Participation (CoPs)	MS State Minimum Standards
	mental 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. ***(g) Standard: Hospice aide assignments and duties.*** (1) 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. (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. (3) 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. (iii) Assistance in ambulation or exercises. (iv) Assistance in administering medications that are ordinarily self administered. (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. Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures. ***(h) Standard: Supervision of hospice***	

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LA State Minimum Standards	Medicare Conditions of Participation (CoPs)	MS State Minimum Standards
	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. (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. (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 in accordance with § 418.76(c). (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. (3) The supervising nurse must assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include, but is 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. ***(i) Standard:*** Individuals furnishing Medicaid personal care aide-only services under a Medicaid personal care	

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LA State Minimum Standards	Medicare Conditions of Participation (CoPs)	MS State Minimum Standards
	benefit. An individual may furnish personal care services, as defined in § 440.167 of this chapter, on behalf of a hospice agency. (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. (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. (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. ***(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. ***(k) Standard: Homemaker supervision and duties.*** (1) Homemaker services must be coordinated and supervised by a member of the interdisciplinary group. (2) Instructions for homemaker duties must be prepared by a member of the interdisciplinary group. (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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LA State Minimum Standards	Medicare Conditions of Participation (CoPs)	MS State Minimum Standards
	§ 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.	
§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. .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 realistic 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.	**§ 418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services.** ***(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 needs.	**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. 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; 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

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LA State Minimum Standards

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.
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.

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;
2. nursing services, physician services, and drugs and
biologicals are routinely available to hospice patients on a 24- hour basis, seven days a week;
3. all other covered services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions;
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;

Medicare Conditions of Participation (CoPs)

(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-

MS State Minimum Standards

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.
d. The hospice will designate a registered nurse to coordinate the implementation of the POC for each patient.

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;
b. Nursing services, physician services, and drugs and biologicals are routinely available to hospice
patients on a 24 hour basis, seven days a week;
c. All other covered services are available on a 24 hour basis to the extent necessary to meet the needs
of individuals for care that is reasonable and necessary for the palliation and management of
terminal illness and related conditions;
n. Supervision and professional consultation by qualified personnel, available

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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.	to staff and volunteers during all hours of service; o. Hospice care provided in accordance with accepted professional standards and accepted code of ethics;
	Non-Core Services **§ 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.	**PART VI BASIC HOSPICE CARE** **117 OTHER SERVICES** 117.05 Hospice aide services shall be available and adequate to meet the needs of the patient. The hospice aide shall meet the federal and state training requirements.
§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. 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.	**§ 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 notes. (3) Responses to medications, symptom management, treatments, and services. (4) Outcome measure data elements, as described in § 418.54(e) of this subpart.	**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. 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

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LA State Minimum Standards	Medicare Conditions of Participation (CoPs)	MS State Minimum Standards
		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: 6. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.)
§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. 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.	**§ 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.	**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.: 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.

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briefs

Martha McDurmond, Administrator, Hospice of Shreveport/Bossier (pictured) and Nancy Dunn, LMHPCO Education Director presented "Planning for Success: Implementing the Newly Revised Medicare Hospice CoPs" at the 318 Area Code Meeting on February 20, 2009. The meeting was held at the Christus Schumpert Medical Center Auditorium in Shreveport with 60 people in attendance. A special thanks to Robin Loucke of Grace Home Hospice for securing the location.

A special thanks to Hospice of Shreveport/Bossier for coordinating registration at the 318 Area Code Meeting. Pictured (left to right) are Terri Catlett, Volunteer Coordinator, Kay Stevens, Volunteer and Jean Bailey, Volunteer. Thanks ladies for a job well done!

Calendar

www.LMHPCO.org

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

March 12, 2009
Area Code 662 Chaplain/Bereavement Coordinator In-service
For more information, contact Nancy Dunn at nancy@LMHPCO.org

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

April 14, 2009
Area Code 228 Meeting
For more information, contact Suzanne MaGee at smagee@mhg.com

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

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 3/2/2009)

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Agape Northeast Regional Hospice, LLC, West Monroe, LA
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AseraCare Hospice, LLC, Philadelphia, MS
AseraCare Hospice, LLC, Senatobia, MS
AseraCare Hospice, LLC, Starkville, MS
AseraCare Hospice, Tupelo, MS
Baptist Hospice - Golden Triangle, Columbus, MS
Bayou Region Hospice, Houma, LA
Circle of life Hospice, Inc, Shreveport, MS
Christus Cabrini Hospice, Alexandria, LA
Christus Schumpert Community Hospice, Shreveport, LA
Camellia Home Health & Hospice, Bogalusa, LA
Camellia Home Health & Hospice, Columbia, MS
Camellia Home Health & Hospice, Hattiesburg, MS
Camellia Home Health & Hospice, Jackson, MS
Comfort Care, Laurel, MS
Community Hospice of America, McComb, MS
Community Hospice of America, Meridian, MS
Community Hospice of America, Natchez, MS
Community Hospice of America, Shreveport, LA
Community Hospice, Inc, Sherman, MS
Continue Care Hospice, Hollandale, MS
Crossroads Hospice, LLC, Delhi, LA
Delta Regional Medical Center Hospice, Greenville, MS
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
Forrest General Hospital, Hattiesburg, MS
Generations Hospice Service Corp, Denham Springs, LA
Guardian Hospice Care, LLC, Alexandria, LA
Guardian Hospice, Inc, Jefferson, LA
Gulf Coast Hospice, Ocean Springs, MS
Hospice Associates, Metairie, LA
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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
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Hospice of Light, Lucedale, MS
Hospice of Caring Hearts, LLC, Dubach, LA
Hospice of Shreveport/Bossier, LA
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IBC Hospice, Youngsville, LA
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LifePath Hospice Care Services, 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
Memorial Hospice at Gulfport, Gulfport, MS
Mid-Delta Hospice, Batesville, MS
My Hospice, Metairie, LA
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Odyssey Healthcare, Jackson, MS
Odyssey Healthcare of the Gulf Coast, Gulfport, MS
Odyssey Healthcare of the Gulf Coast, Biloxi, MS
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