Medicare Conditions of Participation (CoPs)
Knowledge Base for End-Of-Life Doulas

Why We Include Medicare CoPs in the NEDA Certificate of Proficiency Assessment

At this time, EOLDs are not included as part of the hospice interdisciplinary team who deliver medical and non-medical end-of-life care and support, which is reimbursable by Medicare. Therefore, EOLDs are not bound by these regulations. However, NEDA includes them in this assessment to encourage doulas to learn more about the hospice system and government requirements, and to be positioned if/when hospices are able to expand professional services to include EOLDs in the patient care plan for pay. Outside of Medicare reimbursements, hospices who wish to incorporate doulas into their service packages for hire or for some form of compensation may consider various financial models. Familiarity with hospice personnel, duties, philosophy, culture, and services is beneficial to EOLDs and the families they serve who are on hospice service.

While the primary CoPs that would be of interest to EOLDs are located in the Volunteer section, each statute included here has implications for EOLDs who may choose to explore opportunities with hospice in addition to their doula role. Keep in mind that Medicare-certified hospices must provide training for their volunteers, so EOLDs who choose to volunteer in any capacity will be asked to complete hospice in-house training, in addition to any formal doula training they may already have taken.

At the end of each section, we have included questions that are specific to what might be of interest to EOLDs, and that may be included on the assessment to make studying them more focused and meaningful.

For the full Medicare Conditions of Participation, see
https://weatherbeeresources.com/images/uploads/Clean_CoPs_2016_September.pdf

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§ 418.3 Definitions

For purposes of this part—

Attending physician means

1) (i) Doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs that function or action; or
(ii) Nurse practitioner who meets the training, education, and experience requirements as described in § 410.75 (b) of this chapter.

2) Is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

Bereavement counseling means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment.

Cap period means the twelve-month period ending October 31 used in the application of the cap on overall hospice reimbursement specified in § 418.309. Caps are limitations on the amount of reimbursement hospices can receive for both inpatient care and care rendered in the aggregate. For more

information on how caps work within hospice settings, see: http://www.nhpco.org/press-room/press-releases/caps-and-limitations

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.

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.

Dietary counseling means education and interventions provided to the patient and family regarding appropriate nutritional intake as the patient's condition progresses. Dietary counseling is provided by qualified individuals, which may include a registered nurse, dietitian or nutritionist, when identified in the patient's plan of care.

Employee means a person who:

1) Works for the hospice and for whom the hospice is required to issue a W–2 form on his or her behalf;
2) If the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice; or
3) Is a volunteer under the jurisdiction of the hospice.

Hospice means a public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care as defined in this section.

Hospice care means a comprehensive set of services described in 1861(dd)(1) of the Act, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

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.

Multiple location means a Medicare-approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice issued the certification number. A multiple location must meet all of the conditions of participation applicable to hospices.

Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

Physician means an individual who meets the qualifications and conditions as defined in section 1861(r) of the Act and implemented at § 410.20 of this chapter.

Physician designee means a doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available.

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.

Restraint means—

1) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort); or
2) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Seclusion means the involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving.

Social worker means a person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education.

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.

- **EOLDs working with hospice should be conversant with the terms used**

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

The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.

(a) *Standard: Initial assessment.* The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with § 418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)

(b) *Standard: Timeframe for completion of the comprehensive assessment.* The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with § 418.24.

(c) *Standard: Content of the comprehensive assessment.* The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following factors:

(1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).
(2) Complications and risk factors that affect care planning.

(3) Functional status, including the patient's ability to understand and participate in his or her own care.
(4) Imminence of death.
(5) Severity of symptoms.
(6) *Drug profile*. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:
(i) Effectiveness of drug therapy.
(ii) Drug side effects.
(iii) Actual or potential drug interactions.
(iv) Duplicate drug therapy.
(v) Drug therapy currently associated with laboratory monitoring.
(7) *Bereavement*. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.
(8) The need for referrals and further evaluation by appropriate health professionals.

(d) *Standard: Update of the comprehensive assessment*.
The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.

(e) *Standard: Patient outcome measures*.
(1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.
(2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.

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 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.

(2) If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services.

(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.
(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 services 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.

A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section. A hospice may use contracted staff, if necessary, to

supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. A hospice may also enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice employee/staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include: Unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside of the hospice's service area.

(a) *Standard: Physician services.* The hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.

(1) All physician employees and those under contract, must function under the supervision of the hospice medical director.

(2) All physician employees and those under contract shall meet this requirement by either providing the services directly or through coordinating patient care with the attending physician.

(3) If the attending physician is unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient.

(b) *Standard: Nursing services.*

(1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.

(2) If State law permits registered nurses to see, treat, and write orders for patients, then registered nurses may provide services to beneficiaries receiving hospice care.

(3) Highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive, may be provided under contract.

(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.

(d) *Standard: Counseling services.* Counseling services must be available to the patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process. Counseling services must include, but are not limited to, the following:

(1) *Bereavement counseling.* The hospice must:

(i) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling.

(ii) Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/IID when appropriate and identified in the bereavement plan of care.

(iii) Ensure that bereavement services reflect the needs of the bereaved.

(iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in § 418.204(c).

(2) *Dietary counseling.* Dietary counseling, when identified in the plan of care, must be performed by a qualified individual, which include dietitians as well as nurses and other individuals who are able to address and assure that the dietary needs of the patient are met.

(3) *Spiritual counseling.* The hospice must:

(i) Provide an assessment of the patient's and family's spiritual needs.

(ii) Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires.
(iii) Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability.
(iv) Advise the patient and family of this service.

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 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 16 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.
(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 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.

(f) *Standard: Eligible competency evaluation organizations.* A hospice aide competency evaluation program as specified in paragraph (c) of this section may be offered by any organization except by a home health agency that, within the previous 2 years:

(1) Had been out of compliance with the requirements of § 484.36(a) and § 484.36 (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 governmental authority to oversee the operation of the home health agency and to ensure the health and safety of the home health agency's patients.
(v) Been closed by CMS or the State, or had its patients transferred by the State.

(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 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 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.

- **What are hospice's goals and philosophy?**
- **What specific services do hospices offer?**
- **What four levels of care must be assessed for acceptance into hospice service?**
- **What eight factors must be addressed during the initial assessment?**
- **What key professionals must be included in hospice interdisciplinary groups?**
- **What six services must be offered to hospice patients and their families that are outlined in their individual care plan?**

- **What is included in a hospice patient plan of care?**
- **What professionals does hospice employ to serve patients and families?**
- **Who is responsible for coordinating spiritual care?**
- **What duties and services do hospice aides perform?**
- **What training is required for paid hospice aides?**
- **What is HIPAA?**
- **Who at hospice must be called should there be a medical, family, or spiritual concern with patient/family care?**

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§ 418.78 Conditions of participation - Volunteers.

The hospice must use volunteers to the extent specified in paragraph (e) of this section. These volunteers must be used in defined roles and under the supervision of a designated hospice employee. *Volunteers are considered hospice employees to facilitate compliance with the core services requirement.*

(a) *Standard: Training*. The hospice must maintain, document, and provide volunteer orientation and training that is consistent with hospice industry standards.

(b) *Standard: Role*. Volunteers must be used in day-to-day administrative and/or direct patient care roles.

(c) *Standard: Recruiting and retaining*. The hospice must document and demonstrate viable and ongoing efforts to recruit and retain volunteers.

(d) *Standard: Cost saving*. The hospice must document the cost savings achieved through the use of volunteers. Documentation must include the following:

(1) The identification of each position that is occupied by a volunteer.

(2) The work time spent by volunteers occupying those positions.

(3) Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions identified in paragraph (d) (1) of this section for the amount of time specified in paragraph (d) (2) of this section.

(e) *Standard: Level of activity*. Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked.

- What is the difference between a volunteer and an EOLD?
- If you are volunteering for a hospice, and are also an EOLD, what "hat" are you wearing when on a patient assignment from hospice?
- If you are a nurse, chaplain, or other healthcare professional, and are practicing as an EOLD, how to you differentiate your services?
- As a volunteer, you are responsible for documenting a patient visit – are you responsible for documenting as an EOLD?
- As a volunteer, to whom do you report at the hospice?
- What are the two (2) types of volunteers?
- What percentage of all patient hours needs to be delivered by volunteers in a hospice setting?
- What is the reporting process for volunteers?
- If HIPPA applies to you as a volunteer, but you are also a Doula, where it does not apply—how do you handle confidentiality?

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§ 418.202 Covered services.

All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

(a) Nursing care provided by or under the supervision of a registered nurse.

(b) Medical social services provided by a social worker under the direction of a physician.

(c) Physicians' services performed by a physician as defined in § 410.20 of this chapter except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.

(d) *Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home*. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.

(e) *Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or SNF, that additionally meets the standards in §418.202 (a) and (e) regarding staffing and patient areas*. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management. Inpatient care may also be furnished as a means of providing respite for the individual's family or other persons caring for the individual at home. Respite care must be furnished as specified in § 418.108(b). Payment for inpatient care will be made at the rate appropriate to the level of care as specified in § 418.302.

(f) *Medical appliances and supplies, including drugs and biologicals*. Only drugs as defined in section 1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as described in §410.38 of this chapter as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care and that are for palliation and management of the terminal or related conditions.

(g) *Home health or hospice aide services furnished by qualified aides as designated in § 418.76 and homemaker services*. Home health aides (also known as hospice aides) may provide personal care services as defined in §409.45(b) of this chapter. Aides may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing bed linens or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in maintenance of a safe and healthy environment and services to enable the individual to carry out the treatment plan.

(h) Physical therapy, occupational therapy and speech-language pathology services in addition to the services described in § 409.33 (b) and (c) of this chapter provided for purposes of symptom control or to enable the patient to maintain activities of daily living and basic functional skills.

(i) Effective April 1, 1998, any other service that is specified in the patient's plan of care as reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions and for which payment may otherwise be made under Medicare.

- Are items or services covered by hospice if they are not related to the terminal illness?
- In what scenario would chemo be covered in a hospice setting?
- If a patient is on hospice, where medical care is covered only for the terminal illness, and offered as comfort care, not curative, is the patient covered for a fall that breaks a bone?
- Can an LPN provide nursing care?
- Are all supplies, equipment and medications covered by Medicare, or only those related to the terminal diagnoses?
- Under what conditions is an inpatient stay covered in hospice?
- Are hospices able to hire, or pay EOLDs, even if they are not part of the interdisciplinary team?