DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

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DATE: **May 3, 2001**

FROM: Director
Survey and Certification Group
Center for Medicaid and State Operations

SUBJECT: Response to Questions from the National Hospice and Palliative Care Organization (NHPCO)

TO: Associate Regional Administrators, DMSO
State Survey Agency Directors

The purpose of this memorandum is to provide you with our answers to questions which we received from the NHPCO. We are including them for your files.

1.Q. Providers rely on the State Operations Manual (SOM) as the official guide for the survey process. However, in some areas of the country, surveyors are not following the SOM. Does the Health Care Financing Administration (HCFA) hold its surveyors accountable to the SOM? What recourse does a hospice program have if a surveyor does not follow the SOM and its protocols?

A. Survey protocols contained in the SOM are established to provide surveyors with guidance in conducting surveys to assess the compliance of providers and suppliers participating in the Medicare and Medicaid programs with certain regulatory requirements. The purpose of the protocols is to provide instructions, check lists and other tools for use both in preparation of the survey and when performing the survey. Survey protocols are to be used by all surveyors to measure compliance with Federal requirements.

The State or Federal surveyor may find that an agency's deficiencies in meeting statutory or regulatory requirements may be based on observations other than those mentioned in the SOM because the guidelines cannot provide an exhaustive, all-inclusive listing of the circumstances which might indicate violations of the requirements.

If the hospice has concerns about the performance of the surveyor, it should initiate discussions with the surveyor and State agency supervisor. If these conversations are unproductive, the HCFA regional office should be notified.

2.Q If the hospice does not routinely manage peripherally inserted central catheter (PICC) lines or other highly specialized nursing services, can it contract for the service? Isn't this an example of an extraordinary circumstance?

A. Nursing services are core services and as such are subject to the core services requirements contained at 42 CFR 418.80. Substantially all hospice core services must be routinely provided directly by hospice employees and cannot be delegated or otherwise furnished under arrangement. We would expect the hospice to employ sufficient RNs who have the educational preparation and attainment of clinical competence to manage the ongoing needs of the hospice's patients.

3.Q. Although the entire interdisciplinary (IDG) group regularly reviews and updates the plan of care, the often rapidly changing and sometimes urgent needs of the patient/family warrants immediate response and change in the plan of care. Response most often is from a nurse, particularly an on-call nurse, in collaboration with the attending physician, but can also be from a social worker. Calling together the entire IDG specifically to approve a care plan change within the scope of practice of one of its members is inefficient. Within what time frame must the entire IDG communicate?

A. The hospice physician and IDG are responsible for establishing a system of communication and integration of services that ensures that the plan of care continues to be reviewed and updated to serve the dying person and his/her family well. There is nothing in the statute or regulation, which requires the IDG to meet every time a change is necessary to the plan of care. There are, however, statutory and regulatory requirements for an IDG approach to caring for the hospice patient. What is critical to hospice care is that the IDG identify through its ongoing assessment when a change is needed to care for the patient and assure that the patient/family receive the care and services necessitated by the change. The hospice must then follow its own system of communication, which has been established by the IDG to ensure that the plan is reviewed and updated by the IDG when any changes are warranted. For example, the hospice IDG must agree to communicate at appropriate intervals specified in the plan of care. If a nurse assesses a patient's pain on a Thursday evening and determines that the medication is not effective, the nurse and the physician can make a change to the medication and plan of care and implement this change immediately. However, the nurse and physician must communicate this change in the plan of care to the other IDG members promptly so that the patient receives the benefit of a full interdisciplinary assessment regarding his/her change in condition. In this way the patient receives the benefit of the entire IDG's assessment of the patient's needs which would include the nurse and physician's assessment and interventions regarding the pain management issue. The IDG can then revise the plan of care as appropriate to address the change in the patient's condition. The IDG can often improve their plan of care by planning ahead for expected problems so that decisions can reflect the patient/family preferences rather than be a response to a crisis. Please refer to our policy memo dated August 19, 1998, for a full discussion of our policy on the hospice IDG. This memo is available on our hospice web site.

4.Q. Are standing and/or routine orders allowed? Can plan of care visit frequencies include PRN orders?

A. The plan of care for a hospice patient, which includes any physician orders, must be established by the attending physician, the medical director or physician designee and the interdisciplinary group prior to providing care. Standing orders or routine orders must be individualized to the patient and are not allowed unless they meet this criteria.

The plan of care must state in detail the scope and frequency of services needed to meet the patient's and family's needs. The plan of care may include PRN orders for visit frequencies to ensure the most appropriate level of service is provided to the patient. A range of visits is acceptable as long as it continues to meet the identified needs of the patient/family. Ranges that include "0" as a frequency are not allowed.

5.Q. Hospice nurses routinely counsel patients/families on nutritional status/interventions due to the anticipated nutritional decline in the terminally ill. When would it be essential to request a dietician consultation?

A. Hospices should provide dietary counseling to hospice patients who experience unmet nutritional needs. This could include patients with dysphagia or other swallowing problems, problematic enteral feedings, unresolved nutritional issues secondary to nausea, vomiting, or the dying process.

6.Q. Are signed physician orders and communication procedures sufficient to demonstrate that the attending physician is involved in the patient's plan of care?

A. No. The plan of care should clearly reflect the ongoing interventions of the interdisciplinary group with the patient's attending physician e.g., telephone contact, verbal orders, progress notes, clinical notes, and plan of care issues.

7.Q. If the SNF/NF was handling a medical concern unrelated to the terminal illness, prior to the patient electing hospice, can the SNF/NF continue to manage the care?

A. When a hospice patient resides in a nursing facility and the patient has a condition that has been identified by the IDG as unrelated to the terminal illness, the SNF/NF may continue to care for that condition as outlined in the coordinated plan of care. Please refer to section 2082 of the SOM for a full discussion of our policy on the hospice care to a resident of a SNF/NF. This section is also available at our hospice web site.

8.Q. Some surveyors have expected documentation that the medical director or physician designee was involved in every change in patient care for every patient. What activities by the medical director are necessary to meet this condition?

A. The medical director is required by regulation to assume overall responsibility for the medical component of the hospice's patient care program. In addition, the physician employees of the hospice, including the physician members of the IDG must also meet the general medical needs of the patient to the extent that these needs are not met by the attending physician. Hospice physician involvement in the plan of care must be evident in the documentation in the clinical record.

Effective Date: The information contained in this memorandum is current policy and is in effect.

Training: This policy memorandum should be shared with all the hospice surveyors, their managers, State and Regional office training coordinators and appropriate staff.

If you would like to discuss any of these issues further, please contact Mavis Connolly of my staff at 410-786-6707.

/s/
Steven A. Pelovitz