MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE AND SAFTETY COMMITTEE
MONTANA STATE SENATE

FEBRUARY 2, 1983

The meeting of the Public Health, Welfare and Safety Committee was called to order by Chairman, Tom Hager on Wednesday, February 2, 1983 in Room 410 of the State Capitol Building.

ROLL CALL: All members were present with the exception of Senator Stephens, who was excused. Woody Wright, staff attorney, was also present.

Many, many visitors were also in attendance.

CONSIDERATION OF SENATE BILL 214: Senator Ed Smith of Senate District #1, sponsor of Senate Bill 214, gave a brief resume of the bill. This bill is an act authorizing the Department of Institutions and the Department of Social and Rehabilitation Services to certify mental health professional persons and granting the departments rulemaking authority.

Senator Smith turned the hearing over to Curt Chisolm, the deputy director for the Department of Institutions, in order that he may attend another hearing.

Mr. Chisolm stated that the Department is asking that it be given broad authority to adopt rules imposing requirements on who shall be considered a professional person in the field of mental health. This bill will address the type of education that an individual has received, the type of experience or training, the type of continuing education or training, and the methods of monitoring compliance and maintaining it.

Jerry R. Hoover, representing the Department of Institutions, stood in support of the bill.

Judith Carlson, representing the Department of Social and Rehabilitation Services, stood in support of the bill. She stated that the Department has had no authority in regards to mental health up to this point.

With no further proponents, the meeting was opened to opponents.

Shirley Thennis, representing the Montana Nurses Association, stated her groups opposition to the bill. She said to certify someone who has been certified by the Department as a professional is to vague. She stated that it is wrong to give the department rule making authority with such broad guidelines as "with reference to national standards."

The meeting was opened to a question and answer period from the Committee.

Senator Marbut asked if certification is already a law. This is a federal law and nationally accepted, however, it does need to be defined more. Academic creditenials, qualifications are needed with a more specific definition, especially in the best interest of the patient.

Senator Himsl asked about the educational criteria for certification.

CONSIDERATION OF SENATE BILL 208: Senator Judy Jacobson, chief sponsor of Senate Bill 208, gave a brief resume of the bill. This bill is an act defining a HOSPICE for licensing purposes; requiring the Department of Health, and Environmental Sciences to adopt rules setting standards for licensing a Hospice; requiring department to license a Hospice approved by the Commission on Accreditation of Hospitals.

Senator Jacobson gave a brief resume of the bill. This bill was introduced at the request of the Hospice Exchange Council to further Hospice development in Montana. It has three parts. The first is a definition of hospice on page 4, which would be a new paragraph in a lengthy definition of the principal functions of hospice. It starts with a terminally ill person and his family and describes how hospice helps them deal with the various stresses of dying.

The second part of the bill is on page 9, this gives the state Department of Health and Environmental Sciences the duty to set up standards for hospice programs to meet and provide some legislation guidelines for setting these standards. A hospice team must be medically directed, under a physician's ultimate supervision. The last part of the bill calls for deemed status licensure when a hospice receives JCAH accreditation. This is important to those hospice programs operated within hospitals, which some, but not all, hospice programs are.

Roger Tippy, representing the Montana Hospice Exchange, stated that the hospice movement has been active in Montana for several years; Congress' recognition of hospice as a reimburseable service under medicare gives them reason to ask the legislature to license hospice programs. Not people, but programs. Mr. Tippy presented the Committee with written testimony. See exhibit 1.

Sue Twidwell, President of the Montana Hospice Exchange Council, stood in support of the bill. She handed out a large folder of information in regards to Hospice to every member of the Committee. (See exhibit 2.) Mrs Twidwell statdd that a license will preserve the high quality of care now afford to people involved in Hospice. Eighteen states now have licensure for Hospice. Sometime unscrupulous people take advantage of people that are terminally ill and their families at the vulnerable time in their lives. Senate Bill 208 would insure quality; 2) no duplication of services; and 3) reimburse Medicare.

Lynn James, representing the Hospice of St Peter's Hospital in Helena, stood in support of the bill. She stated that Hospice volunteers go through intensive training to be able to best cope with being a Hospice volunteer. Many people are involved, from the social worker, minister, registered nurses and many more people. This is a very necessary bill.

Hazel Murray, representing the Hospice of St. Peter's Hospital, stated she is in support of SB 208 for licensing of Hospice. The given support as an active volunteer of Hospice has been very valuable. Hospice volunteers are both a friend and a supporter. Mrs. Murray presented to the Committee a handout entitled "Role of the Volunteer" for potential volunteers in the Hospice Program. See exhibit 3.

George Fenner, administrator of the Division of Health Services and Medical Facilities and represent the Department of Health and Environmental Sciences. Mr. Fenner stated that the department would like to see an amendment added to the record for SB 208. Page 9 , line 25 and ending on page 10 line 4, to be deleted from the bill. This section deals with licensure based on approval of the Hospice by Joint Commission on Accreditation of Hospitals. Licensure is a state responsibility. J.C.A.H. has no regulatory authority by virtue of their organization. There is no provision for consultation to the providers they serve as well as no provision for follow-up visits to verify correction of deficiencies to meet compliance with their standards. A basic J.C.A.H. operational tenet is that providers of health care should voluntarily assess the quality of the care they render. Since participation in the program in voluntary, the approach is necessarily one of peer review. While such an operational mode may be benefical for educational and consultative programs, it does not lend itself to evaluation, monitoring and adverse action. There is no doubt that J. C. A. H. scrutiny can be purely objective when modified by the need for program participants to generate funds to meet operational costs. No such modifying circumstance exists relative to state licensure. All service providers must comply with existing state requirements in order to operate. If non-compliance is determined the State Agency has the option of revoking the license or imposing civil penalty. J. C.A.H. will not release its reports to the public and does not maintain an office in Montana so that it can be responsive to citizens complaints, questions or concerns. Mr. Fenner handed in written testimony to the Committee. See exhibit 4.

Lindy Gochanour, representing the Anaconda Pintler Hospice, stood in support of the bill. She stated that to become a volunteer, she attended 24 hour volunteer orientation programs, filled out an application, and was then interviewed by a volunteer coordinator. This investment has been one of the most rewarding experiences of her life. She has learned alot about caring, giving, feelings, living, dying and much more. A volunteer has to be prepared to give alot of himself. Mrs. Gochanour then told of the role of the Hospice volunteer. Hospice volunteers are also provided with continuing education about different aspects of Hospice. The purpose of Hospice is to provide care that will enhance the quality of the remaining life for those who are facing a terminal illness. Hospice care can make this difficult time in a person's life easier. The volunteers cannot take away the emotional trauma for them or the family, but they can be helped through it. Hospice licensure would be very helpful because it would insure Volunteer Professional support. It would insure standards of training, and it would allow clients to stay at home, in familiar surroundings and would help to keep the medical costs down. Mrs. Gochanour presented written testimony for the record. See exhibit 5.

James Milo Manning, representing the Anaconda Pintler Hospice, told of his family's personal experience with the Hospice Program during the terminal illness of his mother. Mr. Manning stated that his family has learned that the Hospice organization is a most worthwhile and needed organization, both to the patients and their families in preparing and accepting death. As the funds to enable the organization to operate come from donations, memorials, and grants from private companies, it is necessary to give the Hospice Organization the needed recognition and legitimacy to attract funding. Every organization needs some supervision and Senate Bill 208 would provide that. Mr. Manning presented written testimony to the Committee. See exhibit 6.

Gene McLatchey, representing himself from Helena, stood in support of the bill. He stated that he felt that the Hospice Program is very worthwhile and needed program. Mr. McLatchey told of his personal experience with Hospice during the recent illness and death of his father. Hospice is a very wonderful experience and a valuable asset to our community.

Maureen O'Reilly, representing West-Mont Community Care, presented a letter from the Janice Treml, National Hospice President, in regards to pending legislation on the national level. She then presented the letter to the Committee for the record. See exhibit 7.

J. W. Greene, executive vice president of the Anaconda Pintler Hospice, stated that the Hospice movement seeks to provide unlimited caring for patients and their families as the patient passes through the last journey of life. The Hospice movement recognizes dying as a natural process and seeks to increase the quality of the time remaining for the patient. Hospice provides support to the family through its services and aids the family in caring for the ill member. Senate Bill 208 seeks to define a Hospice for licensing purposes. A real need exists for licensing, in view of the new Federal laws which will allow Medicare payments for services rendered by Hospice organizations. A means must be found to insure that all Hospice organizations statewide provide quality care for patients and the most effective means to do this is through state-wide licensing and adopting standards for accreditation. The Federal Law dictates that a Hospice can be either a public or a private group, must provide 24 hour care, bereavement care, uses the interdisciplinary team approach, provides or supervises Hospice services and is licensed according to state law. See exhibit 8.

Kevin McNeils, of the Anaconda Pintlar Hospice, stated that he is in favor of SB 208 because the Hospice Organization plays a very important part in the city of Anaconda in dealing with the concerns and problems that face all of us in death. He would support any legislation that will benefit the Hospice Program.

Chad Smith, representing the Montana Hospital Association, stated that he recognizes the need for this bill. However, he is concerned with the licensing upon licensing. Mr. Smith offered an amendment on Pages 9 and 10 by deleting line 25 on page 9 and lines 1 through 4 on page 10, and substituting in leiu thereof the following: "NEW SECTION, Section 3. Exemption from licensing. No licensed hospital shall be required to obtain additional licensing to perform hospice services." See exhibit 9.

Marilyn McKibben, representing herself, stated that from the very beginning the Montana Hospital Association never voiced their concerns with the bill until now. It seems to be counterproductive. Hospice needs to be standarized.

With no further proponents, the meeting was opened to the opponents. Hearing none, the meeting was opened to a question and answer period from the Committee.

Senator Christiaens asked about the programs. He was told that there is no duplication in services, there is no charge for services they are operated solely on donations and grants. The federal legistion may bring about Medicare reimbursement.

Senator Himsl asked about Medicare/Medicaid funds. This bill does not address that issue, however, there is federal legislation that may address the issue.

Senator Hager asked if there are any insurance companies which will cover Hospice now. Blue Shield/Blue Cross will cover at the present time. There are some national companies which will also cover Hospice.

Senator Hager asked about preventing abuse of the program. The Department of Health will set standards to prevent this from happening.

Senator Himsl asked if the people wanted the Department of Health to come to each hospital to review the programs. The program is licensed not the people.

Senator Hager asked about the cost of administering this proposal. Mr. Fenner stated that the cost would not be significant.

Senator Jacobson closed. She expressed her gratitude to the many people which came to the hearing and testified on behalf of the bill. She asked the Committee to give this bill favorable consideration as it is a very good bill.

CONSIDERATION OF SENATE BILL 209: Senator Harold Dover, chief sponsor of SB 209, gave a brief resume of the bill. This bill is an act to provide criteria for admissions to the Montana Center for the aged; revising the transfer and discharge procedure.

Senate Bill 209 was introduced to clarify the mission of the Montana Center for the Aged in Lewistown and to establish basic admission procedures. The statutes currently define the Center as a mental health facility. This obligates the center to meet the same treatment and transitional goals as Warms Springs State Hospital.

Senate Bill 209 clarified the role of the center in the overall health service delivery system. The primary function of the center is the care and treatment of persons 55 years of age or older. Priority must be given to patients referred from Warm Springs State Hospital or Galen State Hospital. The Center provides long term care for individuals, who are unable to maintain themselves in their homes or communities due to mild psychiatric impairments associated with the aging process but do not require the intensity of treatment available at Warm Springs or Galen State Hospital. For the vast majority of people, the psychiatric disability is of a chronic nature, often accompanied by physicial deteriation that is associated with old age. The function of the center is to provide a safe and human environment which recognizes human dignity as these elderly people adapt to long term care at the center. The center is not a transitional mental health facility. SB 209 would identify the centers function as one for elderly with mild psychiatric impairment associated with the aging process, make clear to the courts and other mental health facilities, the general public and legislators, as to the center's responsibilities and capabilities, and set up guidelines for development of staffing programs and administrative staff. This change is consistent with the Department of Institutions goal of clarifying the specific mission of each state institution. As the mission of the Center for the Aged has changed to fit within the overall continum of services, it is important that such change receive legislative sanction.

Curt Chisolm, deputy director for the Department of Institutions, stood in support of the bill. He presented to the Committee the Statement of Intent to accompany SB 209. He then gave the Committee a history of the Center. They will accept direct referrals.

Clifford Murphy, representing the Mental Health Association of Montana, stood in support of the bill.

With no further proponents, the chairman called on the opponenents.

Shirley Thennis, representing the Montana Nurses Association, stated that it is difficult to believe that the ommission of family notification can serve any purpose and she for one would be furious if a family member of hers were transfered without her knowledge. These are elderly people. People who are unfortunate enough to have impaired mental abilities, but people just the same. Certainly, these people are far more susceptible to confusion and disorientation, and need time to adjust with family help to any move. Family notification should be required anytime a patient is transfered from one state facility to another, whatever the facilities may be. Mrs. Thennis turned in written testimony to the Committee. See exhibit 10.

With no further oppenents, Senator closed. He stated that there was an error in drafting and that the bill should be amended on page 2, lines 1 through 6. This language should all be reinstated. He asked for favorable consideration on SB 209.

The meeting was opened to a question and answer period from the Committee.

Both Senators Marbut and Himsl questioned the rule making of this bill.

Senator Marbut asked about the name being changed in this bill if the bill regarding name changes of the institutions should pass. Woody stated that the Code Commissioner would handle the name change.

Senator Hager asked Mrs. Thennis if she would support the bill with the amendment proposed by Senator Dover. She stated that the Montana Nurses Association would now support the bill with the amendment.

DISPOSTION OF SENATE BILL 209:

A motion was made by Senator Himsl that the bill be amended to reinstates the stricken language on Page 2, lines 1 through 6. Motion carried.

A motion was made by Senator Himsl that Senate Bill 209 receive a DO PASS, as amended recommedation from the Committee. Motion carried unanimously.

A motion was made by Senator Jacobson that the Statement of Intent for SB 209 be adopted. Motion carried unanimously.

DISPOSTION OF THE AMENDMENTS TO SENATE BILL 214:

A motion was made by Senator Jacobson that the amendments as presented by Judith Carlson be adopted. Motion carried unanimously.

ANNOUNCEMENTS: The next meeting of the Public Health, Welfare and Safety Committee will be held on Friday, February 4, 1983 to consider SB 232, and SB 271.

ADJOURN: With no further business the meeting was adjourned.

Senator Tom Hager

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ROLL CALL

PUBLIC HEALTH, WELFARE, SAFETY COMMITTEE

48th LEGISLATIVE SESSION -- 1983 Date 2/2/8

NAME	PRESENT	ABSENT	EXCUSED
SENATOR TOM HAGER	✓		
SENATOR REED MARBUT	✓		
SENATOR MATT HIMSL	✓		
SENATOR STAN STEPHENS			✓
SENATOR CHRIS CHRISTIAENS	✓		
SENATOR JUDY JACOBSON	✓		
SENATOR BILL NORMAN	✓		

DATE ______________

COMMITTEE ON ______________________________

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppose
JAMES M MANNING	Anaconda Pintler Hospice	SB 208	✓	
JOHN J. CORRIGAN	ANACONDA PINTLER HOSPICE	✓	✓	
Lindy Cochancur	Anaconda Pintler Hospice	✓	✓	
KEVIN McNELIS	" " "	✓	✓	
Marilyn McKibben	self	✓	✓	
S. Marie Noël Bruch	self	✓	✓	
Ed B Smith	Senate	SB214	✓	
J.W. Greene	Anaconda Pintler Hospice	SB208	✓	
Maureen O'Reilly	West-Mont Comm Care	SB208	✓	
Bonnie Allen	self	SB208	✓	
Betty Carlson	self	SB208	✓	
Lynn James	Hospice of St Peters	SB208	✓	
Sue Lindwell	Highlands Hospice	SB208	✓	
Mary Malyevac	Highlands Hospice	SB208	✓	
Betty Wulf	Highlands Hospice	SB208	✓	
Sr. Kathleen O'Sullivan	Highlands Hospice	SB208	✓	
Ruth Dues	Highlands Hospice	SB208	✓	
Mary Matter	Highland Hospice	SB208	✓	
Anne Ziegler	Highland Hospice	SB208	✓	
Chad Smith	Mont Hosp Assn	SB208	(amend)	
Roger Tippy	Mt Hospice Exchange Council	SB208	✓	
Clifford H. Murphy	Mental Health Assoc. of Mt.	SB209 SB214	✓ ✓	
Shirley Thomas	Montana Nurses Assn	S.B214 SB209		
Jerry Hoover	Dept. of Institutions	SB209 SB214	✓ ✓	

(Please leave prepared statement with Secretary)

STATEMENT OF INTENT

SB 214: The Department of Institutions is requesting legislation that will give it and the Department of Social and Rehabilitation Services Rule making authority for the certification of professional persons in the mental health field. The Department of Institutions is requesting that it be given broad authority to adopt rules imposing requirements on who shall be considered a professional person in the field of mental health. The Department is required to adopt such rules and it is contemplated that they should address the following:

a. The types of education that an individual has received, including degrees:

b. The type of experience or training that he has received that may qualify him for a professional person.

c. The type of continuing education or training or instruction that may be necessary to maintain such certification.

d. The standards for waiver of requirements for specific reasons, if any.

e. Methods of monitoring compliance and maintaining it, and

g. Specific due process procedures for the revocation of certification.

-END-

NAME: Murphy, Clifford H. DATE: 2/2/83

ADDRESS: 1301 Rimrock Rd, Billings, MT. 59102

PHONE: 252-1685

REPRESENTING WHOM? Board, Mental Health Assoc. of MT.

APPEARING ON WHICH PROPOSAL: SB 214

DO YOU: SUPPORT? ✓ AMEND? OPPOSE?

COMMENTS: Would like to see two public representatives, perhaps one from d.d. proponent group(s) and one from mental health group proponents, and to learn of committee meetings on rule-making and credentials

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

NAME: Shirley Pennis DATE: 2/2/83.

ADDRESS:

PHONE: 227-6328

REPRESENTING WHOM? Montana Nurses Assn.

APPEARING ON WHICH PROPOSAL: 214

DO YOU: SUPPORT? ☐ AMEND? ☐ OPPOSE? ✓

COMMENTS:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Montana Nurses' Association

2001 ELEVENTH AVENUE (406) 442-6710

P.O. BOX 5718 • HELENA, MONTANA 59604

I am Shirley Thennis of the Montana Nurses' Association. I speak in opposition to SB-214.

To define a professional person only as someone who has been certified by the department is too vague. Are these professionals who have already achieved individual liscensure through an appropriate liscensing body or is this certification in lieu of professional liscensure? If they are already liscensed, why do they need department certification? If they are not already liscensed, on what criteria is the certification being given?

I believe it to be wrong to give a department certifying powers without any reference to the qualifications of those doing the certifying.

It is doubly wrong to give a department rule making authority with such broad guidelines as "with reference to national standards".

Thank you for giving me the opportunity to voice my concerns regarding this bill.

INTRODUCTION TO SB208

This bill is introduced at the request of the Hospice Exchange Council to further hospice development in Montana.

It has three parts. The first is a definition of hospice on page 4, which would be a new paragraph in a lengthy definition of the principal functions of hospice. It starts with a terminally ill person and his family and describes how hospice helps them deal with the various stresses of dying.

The second part of the bill is on page 9; this gives the state department of health and environmental sciences the duty to set up standards for hospice programs to meet and provides some legislative guidelines for setting these standards. A hospice team must be medically directed -- under a physician's ultimate supervision.

The last part of the bill calls for deemed status licensure when a hospice receives JCAH accreditation. This is important to those hospice programs operated within hospitals, which some - but not all - hospice programs are.

NAME: Roger Tippy DATE: February 2, 1983

ADDRESS: P. O. Box 514

PHONE: 442-8070

REPRESENTING WHOM? Montana Hospice Exchange

APPEARING ON WHICH PROPOSAL: Senate Bill 208

DO YOU: SUPPORT? X AMEND? ____ OPPOSE? ____

COMMENTS: Mr. Chairman and committee members, I am Roger Tippy, an attorney here in Helena, representing the Montana Hospice Exchange Council as its lobbyist. I urge your do pass vote for SB208.

The hospice movement has been active in Montana for several years; Congress' recognition of hospice as a reimbursable service under medicare [redacted] gives us reason to ask the legislature to license hospice programs.

Not people, programs. Nothing in this bill calls for the licensing or certification of any individual or any profession. We ask you to add one small duty to an existing agency: the Facilities Licensing and Certification Bureau within the Department of Health and Environmental Sciences. The duties involved -- promulgating a set of standards in the Administrative Rules of Montana and issuing licenses to hospice programs meeting those standards -- no fiscal impact attaches to this bill.

The Hospice Council has endeavored to discuss this bill with other concerned providers and to accommodate their views. Section 2, paragraph (2) is a statement inserted at the request of the Home Health Agencies association. Section 3 has been worked out with the Montana Hospital Association to alleviate their concerns about multiple inspections.

Finally, the bill does delegate rulemaking authority and will require a statement of intent. Materials to be furnished by the next witness, Ms. Sue Twidwell, will include source documents for standards the departments could adopt, and we will furnish the committee with language for a statement of intent referencing these sources.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

HIGHLANDS
HOSPICE, Inc. P.O. Box 267, Butte, MT 59703

JOINT COMMISSION ON THE ACCREDITATION OF HOSPITALS

STANDARDS OF CARE

The development of an alternative support network is needed when no relative or other primary caregiver is available and a patient needs and wants support.

CHARACTERISTICS

1. If the hospice program accepts patients who do not have primary caregivers, there are written policies and procedures that address at least the following:

    A. The responsibility of the program and the efforts program staff will make to identify a primary caregiver(s) for the patient;
    B. The definition of an "acceptable primary caregiver";
    C. What instruction will be given to the primary caregiver by interdisciplinary team members;
    D. The program's responsibility to the primary caregiver; and
    E. Under what circumstances the patient will no longer be eligible to receive hospice program services.

RATIONALE

Hospice care does not proffer a "right way to die." The terminally ill patient's and the family's own framework of values, preferences, and life outlook must be taken into account in planning and conducting treatment.

CHARACTERISTICS

1. The hospice program has a statement of patient/family rights that is written in simple and easy-to-understand terms and in a language understandable to patients/families and is available to them. The rights include, but are not necessarily limited to, the following:

   A. Support and protection of the fundamental human, civil, and legal rights of each patient/family;
   B. Impartial access to treatment, regardless of the patient's or family members' race, religion, sex, ethnicity, age, or handicap;
   C. Recognition of each patient's/family's personal dignity and autonomy and respect for each patient/family in the provision of all care and treatment; and
   D. Individualized treatment for each patient/family, which includes at least;

      (1) the provision of adequate and humane services, regardless of the source of financial support,

      (2) the provision of a care plan,

      (3) periodic review of the care plan,

      (4) the active participation in planning for treatment by all patients who are able to participate and by the responsible parents, relatives, or guardians of minors or legally incompetent patients,

      (5) a statement of charges for services provided, and

      (6) assurance and protection of each patient's/family's personal privacy and the confidentiality of patient-related information within the constraints of the care plan.

GOAL THREE

Program personnel seek to identify, teach, coordinate, and supervise persons other than interdisciplinary team members to give care to patients who do not have a family member of other primary caregiver available, if such patients are eligible for admission to the hospice program.

RATIONALE

Not every patient has a family or family members who are willing to give care.

1st draft 12/27/82 DT

sent to committee 1-13-83

HOSPICE PROJECT STANDARDS

Chapter One

Patient/Family as the Unit of Care

GOAL ONE

The patient and the patient's family is the unit of care.

RATIONALE

Inclusion of the patient's family or significant other(s) in the hospice program is essential, and family members should be encouraged to participate in developing the care plan and in caring for the patient according to their ability to do so. Family members are seen as both primary caregivers and as needing care and support.

CHARACTERISTICS

1. The hospice program has written admission criteria that reflect the following:
    - A. An assessment of the patient's/family's desire and need for hospice services;
    - B. The eligibility of a patient who does not have a designated primary caregiver; and
    - C. Any factors with regard to the patient's diagnosis, prognosis, or receipt of active treatment that may affect eligibility.

2. A consent for care form is signed by the patient, and a family member or other primary caregiver.

3. The patient and the family or other primary caregiver participate in the development of the care plan according to their ability to do so, and such participation is documented in the medical record.

4. The interdisciplinary team care plan includes specific goals for involving family members or other primary caregiver.

GOAL TWO

Hospice program services and care reflect an acknowledgement that each patient-/family has basic rights, individual beliefs, and/or a value system and a life philosophy.

GOAL TWO

Symptom management includes assessing and responding to the psychosocial needs of the patients/families.

RATIONALE

Hospice care recognizes that when a patients/families are faced with terminal disease, stress and concerns may arise in many areas of their lives. Successful symptom management frequently requires concurrent physical and psychosocial intervention to address those concerns and stresses.

CHARACTERISTICS

1. Psychosocial assessment of an intervention with a patient/family are documented in the interdisciplinary team care plan and in progress notes throughout the course of patient care and across disciplines. The following elements of psychosocial symptom assessment and management are documented.

   A. Such symptoms as anxiety or depression;
   B. Family dynamics;
   C. The patient's/family's understanding of the illness and prognosis and their reaction to the course of the illness; and
   D. Interdisciplinary team communication and consultation with the attending physician.

2. Education programs for the introduction and review of psychosocial assessment and intervention are available at least twice annually to interdisciplinary team members. The content of education programs includes, but is not necessarily limited to, the following:

   A. Basic aspects of psychosocial assessment;
   B. Basic communication skills;
   C. Patient/family response to terminal illness and death; and
   D. Family response to bereavement.

1st draft to committee 1-20-83

Chapter Three

Symptom Management

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aT pain and symptom management is provided through appropriate therapies.

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in and symptoms of terminal disease can usually be minimized through the ppropriate palliative treatments that produce the greatest relief from e aused problems for the longest period of time and with the least ffects. In addition, curative treatments are utilized when indicated for al problems secondary to the primary diagnosis.

TERISTICS

ai and symptom management is documented in the interdisciplinary team are plan and in progress notes throughout the course of patient care and cross disciplines. The following elements of pain and symptom management re umented:

- Physical assessment;
- Chronic or acute pain, or a change in pain;
- Symptoms associated with chronic pain;
- Adjustment of pain and symptom modalities as needed;
- Interdisciplinary team communication and consultation with attending physicians;
- Discussion with patients/families about the approach to pain relief as well as instruction regarding any therapies used; and
- Repeated assessments of pain and symptoms, including determinations of compliance with the interventions prescribed.

cation programs for the introduction and review of effective approaches pain and symptom assessment and management are available at least twice nually to interdisciplinary team members. The content of education ograms includes, but is not necessarily limited to, the following:

- Common terminology for use in describing pain and pain relief to patients/families;
- Discussion of approaches to analgesia, including noninvasive approaches, analgesic drugs and their side effects management, surgical approaches, and other treatment modalities; and
- Pain and symptom assessment.

Chapter Four

Home Care and Inpatient Services

GOAL ONE

Hospice program services include home care and inpatient care. The home care and inpatient services are organized, managed, staffed with a sufficient number of personnel, and appropriately integrated with other services of the hospice program.

RATIONALE

Many of the physical and psychosocial needs of the dying patient can be met at home, and being cared for at home can enable the development and continuance of significant human relationships between the dying person and his or her family members. However, hospice care recognizes that the needs of patients/families cannot always be met at home. In those instances when the physical and psychosocial needs of hospice patients necessitate acute care hospitalization, hospice inpatient services must be available.

CHARACTERISTICS

1. There is a written statement of the philosophy and objectives of the home care service and of the inpatient service. The statement includes a description of the services offered in both care settings.

2. All applicable federal, state and local regulations and/or licensure and certification requirements are met by the home care service and the inpatient care service.

3. There are written policies and procedures for the home care services and inpatient services in regard to personnel and the services they provide. These policies and procedures address at least the following:

   A. The qualifications of the physicians who provide care to the patients/families admitted to the hospice program;
   B. The treatment modalities provided, including intravenous procedures, parenteral feedings, chemotheraphy, and the administration of injections; and
   C. The designation of tasks that are performed by home health technicians, home health aides, nurse's aides, and homemakers.

(1) These personnel have satisfactorily completed a structured or on-the-job training program, if such instruction is consistent with legal requirements applicable to the hospice program.

4. There are written policies and procedures for the home care and inpatient services in regard to the resuscitation of patients. These policies and procedures address the following:

   A. The involvement of the patient and the family in deciding whether to resuscitate; and
   B. The attending physician's involvement in, and approval of, the decision.

5. There are written policies and procedures for home care and inpatient services regarding student placement and training in the hospice program. These policies and procedures address at least the following:

   A. The placements and training available;
   B. The supervision, by appropriately qualified hospice personnel, of students when performing patient care; and
   C. The roles and responsibilities of the hospice program and the outside education program if the hospice program provides education and training for students from an outside education program.

6. The hospice program director designates a coordinator of home care and/or inpatient services. A coordinator is responsible for providing administrative direction to home care and/or inpatient services.

7. There is a written statement regarding a coordinator's authority, duties, and responsibilities, which includes, but are not necessarily limited to, the following:

   A. Implementing policies and procedures pertinent to the home care and/the inpatient setting;
   B. Acting as an adviser to the hospice program director;
   C. Directing and, as appropriate, supervising home care and inpatient interdisciplinary team members in their duties;
   D. Participating in the review and evaluation of the quality and appropriateness of patient/family care; and
   E. Preparing and submitting program service reports, which include
      (1) statistical records of the quantity and types of services rendered, and
      (2) records and reports reflecting the nature of the patient population.

8. The scope of services provided, the utilization of services, and the skills necessary to provide the level of care appropriate to the home care and inpatient services are considered when determining the following:

   A. The number, education, and training of qualified personnel necessary; and
   B. Patient-staff ratios for the home care and inpatient services.

(1) An identified methodology that reflects the objectives of the home care and inpatient services is utilized to determine patient-staff ratios.

Home Care Services

GOAL TWO

Home care services are available 24 hours a day, seven days a week.

RATIONALE

The varied physical and psychosocial problems and anxieties associated with terminal illness can occur at any time of the day or night. Hospice care must be available for patients/families whenever it is needed.

CHARACTERISTICS

1. There are written policies and procedures describing the scope of home care services. These policies and procedures pertain to at least the following:
   - A. What services are available on a 24-hour basis seven days a week, including access to pharmacy services;
   - B. Any limitations regarding care provided after normal working hours or on weekends; and
   - C. The method of information exchange between on-call and day-to-day interdisciplinary team members.
2. Unless otherwise provided by law, at least nursing services are available on a 24 hour basis seven days a week.

GOAL THREE

Interdisciplinary team members are prepared to provide care to the patient/family at the time of the patient's death at home.

RATIONALE

A unique aspect of hospice care is the need to prepare interdisciplinary team members for presence before, during, or immediately after the death of a patient at home. To provide supportive continuity of hospice care at the time of death, members must be aware of state and local regulations, laws, and procedures regarding death in the home, as well as the patient's/family's wishes.

CHARACTERISTICS

1. There is a written plan of orientation and inservice training for team members that addresses, but is not necessarily limited to, the following:

A. State and local laws, regulations, and procedures regarding death in the home and the role of the attending physician;
B. A procedure for working with the coroner's office and, as applicable, law officials; and
C. A procedure for the disposal of drugs in the home at the time of death.

Inpatient Services

GOAL FOUR

The inpatient facility or unit has an organized medical staff.

RATIONALE

An organized medical staff is a single identified body that accepts overall responsibility for the quality of medical care provided to patients and the responsibility unless otherwise provided by law, for the qualifications of those individuals licensed to practice medicine and dentistry who care for patients in the inpatient service.

CHARACTERISTICS

1. The medical staff is accountable to patients/families and the hospice program governing body for the quality of medical care provided and for the ethical and professional practice of medical staff members.

2. The medical staff, with the assistance of the medical director, formulates bylaws and rules and regulations necessary for self-governance and for the discharge of the medical staff's responsibilities. The bylaws and the rules and regulations include, but are not limited to, the following:

   A. A descriptive outline of the organization of the medical staff;
   B. A statement of the qualifications a physician must have to be privileged to attend patients in the inpatient facility or unit;
   C. A procedure for granting and withdrawing physician's practice privileges;
   D. Provisions for regular meetings of the medical staff;
   E. Provisions for keeping accurate and complete medical records, which include signed progress notes at the time of each visit and all orders given since the last visit;
   F. Provisions for securing emergency medical care if the attending physician is not available;
   G. Provisions that require a physician's written orders to be recorded and signed;
   H. Provisions that require a physician's verbal and telephone orders to be recorded and signed by the accepting physician, nurse, or pharmacist (in the case of medication orders) and countersigned by the attending physician;
   I. A statement of the necessary qualifications, staff appointments, and rights of dentists, podiatrists, psychologists, nurse practitioners, physician assistants, and other health professions;

J. Provisions for establishing effective controls throughout the medical staff to assure the achievement and maintenance of maximum standards of ethical and professional practices;

K. Provisions for a fair hearing in the event of denial of staff appointment or reappointment or the curtailment, suspension, or revocation of privileges;

L. Provisions for review and evaluation of the quality of services rendered, including the appropriateness of attending physician visit schedules; and

M. A procedure for physician contact and care when neither the attending physician nor the designated alternative are available to examine and treat a patient needing immediate attention.

3. The duties and responsibilities of the medical director of inpatient services include direction of the medical care in the facility or unit.

GOAL FIVE

Provision is made in the inpatient setting for the privacy of patients/families.

RATIONALE

Hospice care recognizes that dying patients and their families continue to have special needs with regard to privacy that need to be respected and accepted within the confines of an inpatient unit or facility.

CHARACTERISTICS

1. Physical space is provided for private patient/family visiting.
2. There are accommodations for family members to remain throughout the night with the patient.
3. Space is provided for family viewing and privacy after a patient's death.

GOAL SIX

The inpatient facility or unit is designed, constructed, equipped, and furnished in a manner that assures the physical safety of patients/families, personnel, and visitors.

RATIONALE

Patients/families, team members, and personnel are entitled to receive and provide care in a building that meets appropriate national standards for construction safety and fire protection.

CHARACTERISTICS

1. The building complies with the 1981 edition of the Life Safety Code (R) of the National Fire Protection Association. The following is required:

   A. Submission of a statement of construction and fire protection. This document is completed by the facility or unit. The information entered in the document is verified and authenticated by an individual who is knowledgeable about institutional construction and fire safety, particularly in regard to health care facilities. Individuals qualified to verify and authenticate the information include registered professional engineers, registered architects, members of the Society of Fire Protection Engineers, or qualified employees of either a fire insurance rating organization or the office of the state fire marshal. It is strongly recommended that such verification or authentification be made following an on-site visit.

   B. A plan of correction for all physical plan deficiencies identified by authorized inspecting agencies and/or indicated in the statement of construction and fire protection. This plan of correction is approved by the authority having jurisdiction and specifies the anticipated time of completion.

   C. A document which certifies that the facility's physical plant is in compliance with the requirements of the 1981 Life Safety Code (R). This documentation may include copies of the state fire marshal's report, state licensure survey reports, or reports of other authorized agencies. Consideration is also given to equivalency when an element of safety is provided at a level equal to or greater than that described in the codes, provided that no other safety element or system is compromised or adversely altered in any way. When alternate protection has been installed and has been accepted by the local authority having jurisdiction, appropriate documentation is required. Copies of all such documentation are available.

   D. If the building is constructed prior to 1973 and the requirements of the standards or their equivalency are not met, the facility institutes and documents--on a sustained basis--extraordinary fire prevention measures in the form of effective housekeeping and maintenance practices, adequate fire-fighting equipment, adequate staffing, and frequent fire drills on all shifts.

GOAL SEVEN

The environment of the inpatient facility or unit is adequate, comfortable, accessible and has sufficient space and equipment for the clinical and personal care of patients.

RATIONALE

Patients/families are entitled to receive clinical and personal care in a comfortable environment that has adequate space and equipment for meeting their needs.

CHARACTERISTICS

1. Adequate, comfortable lighting levels and adequate ventilation through windows, mechanical means, or a combination of both are provided.

2. Sounds are contained at comfort levels.

3. Comfortable room temperatures are maintained.

4. In the event of loss of normal water supply, provision is made to assure that water is available to all essential areas.

5. The facility is accessible to and functional for the physically handicapped. Reasonable accommodations are made in accordance with Standard A117.1, Specifications for Making Buildings and Facilities Accessible to, and Usable by, the Physically Handicapped, of the American National Standards Institute.

6. Each patient/family care area has at least the following:

   A. A nurses' station;
   B. Drug storage and preparation areas; and
   C. Utility and storage rooms.

7. The nurses' station is equipped to register patients'/families' calls through a communication system from patient/family areas, including patient/family rooms and toilet and bathing facilities.

8. Patient/family rooms are designed, equipped, and furnished to comply with all applicable federal, state, and local laws, rules, and regulations, as well as facilitate effective patient/family care and comfort.

9. Each patient/family room is equipped with, or located near, toilet and bathing facilities.

10. Each patient/family room has direct access to a corridor and outside exposure, with the floor at or above ground level.

GOAL EIGHT

The environment of the inpatient facility or unit is functionally safe and sanitary.

RATIONALE

Patients/families, team members, and personnel are entitled to receive and provide care in a facility or unit that is safe and sanitary and in which appropriate measures can be taken in the event of fire, disaster, or other emergency.

CHARACTERISTICS

1. The hospice program director or designee implements and monitors a comprehensive facilitywide or unitwide safety program that is appropriate to the size of the facility or unit.

2. The inpatient team and other personnel as appropriate, are utilized in the development, implementation, and monitoring of safety characteristics and practices to eliminate or reduce hazards to patients/families through the formation of a safety committee.

3. The safety program has written policy and procedures pertaining to at least the following:

   A. The enhancement of safety within the facility or unit and on the facility's grounds;
   B. Coordination of the development of safety rules and practices;
   C. The establishment of an incident-reporting system that includes mechanisms for investigating and evaluating all incidents reported and mechanisms for documenting the review of all reports and actions taken;
   D. The establishment of liaison between the safety committee and the infection control committee;
   E. The provision of safety-related information to be used in the orientation of all staff and volunteers;
   F. The conducting of hazard surveillance programs at specifically defined intervals;
   G. The establishment of methods for measuring results of the safety program;
   H. The establishment of methods, including the review of all pertinent records and reports, to periodically analyze the effectiveness of the safety program; and
   I. The familiarization of facility or unit personnel with applicable federal, state, and local safety regulations.

4. The facility or unit has an available emergency power source that provides essential service when the normal electrical supply is interrupted.

5. Comprehensive safety devices are installed, and safety practices, policies, and procedures are instituted to minimize hazards to patients/families, staff, and visitors.

6. The facility or unit has a written internal disaster and fire plan, as well as fire drills.

7. Sanitation practices, policies, and procedures are implemented to minimize health hazards to all patients/families, staff, and visitors.

GOAL NINE

There is an active inpatient facilitywide or unitwide infection control plan.

RATIONALE

Patients/families, team members, and personnel are entitled to a sanitary and comfortable environment in which measures are taken for the prevention of the development and transmission of infection.

CHARACTERISTICS

1. There is a written plan for the prevention and control of infection and the maintenance of a sanitary environment. The plan pertains to at least the following:

    A. The designation of interdisciplinary personnel responsible for implementing and monitoring the program;
    B. The review of procedures for handling food, processing laundry, disposing of environmental and human wastes, controlling pests;
    C. The review of patient/family care practices, visiting rules for high-risk areas, and access to potential sources of infection;
    D. The monitoring of the health status of employees; and
    E. The monitoring of staff performance to assure that policies and procedures are being followed.

2. There are written policies and procedures for aseptic and isolation techniques, the policies and procedures are

    A. made known to and followed by all staff; and
    B. reviewed annually and revised as necessary.

3. An adequate amount of linen is available at all times for the proper care and comfort of patients.

    A. The linen is handled, processed, stored, and transported in a manner that prevents the transmission of infection.

4. The facility or unit is free of insects and rodents.

GOAL TEN

The inpatient facility or unit provides for the nutritional and special dietary needs of patients/families.

RATIONALE

Hospice care recognizes not only the nutritional and dietetic needs of patients/families, but also the psychological importance of food. The elements of alienation and isolation that may be experienced in an inpatient setting can be reduced with the provision of facilities that increase socialization for patients/families, while meeting patients' nutritional needs.

CHARACTERISTICS

1. Safe, sanitary, and adequately equipped facilities for food preparation by patients/families are provided.

2. Dietetic services are provided directly by the facility or unit or under arrangement with an outside foodservice or management company.

3. Dietetic services are directed by an individual who, by education or specialized training and experience, is knowledgeable in foodservice management.

4. The nutritional aspects of patient care are supervised by a dietitian who is registered by the Commission on Dietetic Registration of the American Dietetic Association or has the documented equivalent in education, training, and experience, as well as evidence of continuing education.

5. The duties of the supervisor of dietetic services include, but are not limited to, the following:

   A. Patient/family consultation;
   B. Participation in patient/family case conferences, as requested;
   C. Approval of menus, including special diets; and
   D. Nutritional assessments of patients.

6. If dietetic services are provided by the facility, the following applies:

   A. The department or service is organized, directed, and staffed to assure the provision of optimal nutritional care and foodservice.
   B. Dietetic personnel are appropriately trained and educated; and
   C. The dietetic department or service area is designed and equipped to provide safe, sanitary, and timely foodservice and to meet the nutritional needs of patients

7. Dietetic services are guided by written policies and procedures.

8. Dietetic services are provided to the patient in accordance with a written order by the attending physician. Appropriate dietetic information is recorded in the patient's/family's medical record.

9. The quality and appropriateness of the nutritional care in meeting the nutritional needs of patients/families are regularly reviewed and evaluated.

GOAL ELEVEN

The pharmaceutical needs of patients are met by the hospice program.

RATIONALE

An integral part of hospice home care and inpatient services is pain and symptom management, and essential to this element of care is meeting the pharmaceutical needs of the patients. Patients/families are entitled to pharmaceutical services that are conducted in accordance with accepted ethical and professional practices and all legal requirements.

CHARACTERISTICS

Home Care and Inpatient Services

1. Only health care practitioners who are authorized by law to write medication orders may do so.

2. Medication orders that contain abbreviations and chemical symbols are filled only if the abbreviations and symbols are on a standard list approved by the medical director and/or medical staff.

3. An individual other than a physician, registered nurse, or licensed practical nurse may administer medications under the supervision of a registered nurse or licensed practical nurse if in accordance with applicable laws and regulations and hospice program policy, and if approved by the attending physician.

4. Self-administered medication is permitted when specifically ordered for the patient by an approved prescriber in accordance with applicable laws and regulations.

5. Before discharge from inpatient services, the patient/family is instructed as to which medications, if any, are to be administered at home and by whom. The patient/family is also instructed as to the preparation, administration, dosages, and precautions to be taken.

6. The medications administered and any adverse drug reactions are documented in the medical record and are periodically reviewed by the attending physician.

7. There is a written policy and procedure regarding medication error follow-up and documentation of any corrective action taken.

8. There are up-to-date resources available to interdisciplinary team members to identify drug side effects and toxic reactions.

9. There is a reporting system for advising the Food and Drug Administration and the drug manufacturer of any unexpected or significant adverse reactions to a drug.

10. Investigational drugs are used only under the direct supervision of an authorized investigator and with the approval of the medical director and the Institutional Review Board. (When hospice inpatient services are provided in a hospital, the hospital's procedures regarding investigational drugs supercedes this standard.)

11. All medication orders are reviewed in accordance with applicable regulations.

12. The pharmacist is experienced in or receives orientation in the specialized functions of the hospice program.

13. The pharmacist is licensed in the jurisdiction of the hospice program.

14. The pharmacist participates in the development of inservice education programs for the hospice program staff.

Inpatient Services

15. Pharmaceutical services for the inpatient facility or unit are provided directly by the facility or the unit or under arrangement.

16. A licensed pharmacist experienced in institutional pharmacy practice is responsible for the development of written policies and procedures to govern the storage, preparation, distribution, and administration of drugs in accordance with applicable federal, state, and local laws and regulations, regardless of the arrangement made for services.

17. A pharmacist makes at least weekly inspections of all drug-storage units, including the emergency cart.

18. In inpatient facilities or units where pharmaceuticals are provided through a community pharmacy, medications are obtained by written prescription from an authorized prescriber only.

19. Any drug brought into the inpatient facility or unit is not administered unless it can be identified, unless a written order to administer it is given by the attending physician, and unless it is judged physically and chemically stable by the pharmacist.

20. The inpatient facility or unit utilizes a drug profile, and a pharmacist regularly reviews the medication records of patients.

21. The inpatient facility or unit has specific policies and procedures for controlling and accounting for drug products. The procedures account for drugs ordered and drugs on hand, as well as their effectiveness dates.

22. Adequate precautions are taken to store medications under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.

23. Drug preparation and storage areas are secure and well lighted.

GOAL TWELVE

The inpatient facility or unit provides, or has delineated access to, radiology services for patients.

RATIONALE

Diagnostic and therapeutic radiology services are necessary for effective pain and symptom management. Radiology services should be conveniently available to meet these needs, as determined by the medical staff, and provided in accordance with accepted professional practices and all legal requirements.

CHARACTERISTICS

1. When radiology services are provided by a facility or unit the type of radiology service available and the arrangements for referring and transferring patients is delineated in a written plan.

2. When radiology services are provided by the hospice inpatient facility or unit, the following apply:

   A. Written policies and procedures govern the operation and inspection of the services, as stated in applicable regulation;
   B. The services are directed by a physician member of the facility staff who is qualified through education and/or experience to assume this function;
   C. Provision is made for appropriate facilities for radiographic and flouroscopic diagnostic services; and
   D. An acceptable method of quality control is used.

GOAL THIRTEEN

The hospice inpatient facility or unit provides, or has delineated access to, pathology and laboratory services in accordance with the needs of patients, the size of the facility or unit, the services offered, and the resources available in the community.

RATIONALE

Pathology and laboratory services are necessary for pain and symptom management. These services should be conveniently available to meet the needs of patients as determined by the medical staff and provided in accordance with accepted professional practices and all legal requirements.

CHARACTERISTICS

1. The means of providing pathology and laboratory services are delineated in a written plan.

2. When pathology and laboratory services are provided by the hospice inpatient facility or unit, the following apply:

   A. Written policies and procedures govern the operation and inspection of the services, as stated in applicable regulations;
   B. The services are directed by a physician member of the facility or hospital staff who is qualified through education and/or experience to assume this function; and
   C. An acceptable method of quality control is used.

GOAL FOURTEEN

The hospice inpatient facility or unit has a written plan delineating the manner in which emergency services are provided.

RATIONALE

Patients/families, staff, and visitors are entitled, at the least, to lifesaving first aide, as deemed appropriate, and referral and ready access to the nearest facility that has the capability of providing emergency services.

CHARACTERISTICS

1. When emergency services are provided by a facility or unit other than the hospice inpatient facility or unit, the type of emergency services available and the arrangements for referring and transferring patients/families, staff, and visitors are delineated in a written plan.

2. When emergency services are provided by the hospice inpatient facility or unit, the type of emergency services available are delineated, and the services provided are organized and properly directed.

1st draft 12/28/81

1st Draft to committee 1-20-83

Chapter Five

Continuity of Care

GOAL ONE

The hospice program provides a continuum of home care and inpatient care through the direct provision of the services or under arrangement.

RATIONALE

Continuity of care in a hospice program is the capacity to respond to patients'/families' needs, whenever and wherever they arise. Hospice patients/families may experience fragmentation and alienation in seeking physical and psychosocial care, but continuity of care in regard to hospice program personnel and services, in both home care and inpatient care settings, can reduce the sense of fragmentation and alienation. Effective administrative and staff integration can assure the continuation of high-quality care for patients/families in both settings.

CHARACTERISTICS

1. Hospice program home care and inpatient services may be provided through various methods, depending on the scope of services offered by the program itself, local hospitals and health care agencies, and other resources in the community.

    A. Home care services may be provided through the following:
        (1) A hospice home care agency; or
        (2) A unit or designated service of a hospital-based, community-based, or public health home care program.
    B. Inpatient services may be provided through the following:
        (1) A hospice inpatient facility; or
        (2) An inpatient unit in a hospital, skilled nursing facility, or intermediate care facility; or
        (3) A scattered-bed or consultation team approach in an acute care hospital.

2. When the hospice program does not directly provide both home care and inpatient care services, there is a written agreement between the hospice program and the provider(s) governing the nature and scope of services and assuring continuity of care. The written agreement addresses at least the following:

    A. What services are provided by each party to the contract;
    B. The qualifications of the personnel providing services;

C. The role and responsibility of the hospice program in the selection, evaluation, orientation, and continuing education of the personnel who provide hospice care;
D. The manner in which services are initiated and coordinated;
E. The respective roles of hospice program interdisciplinary team members, provider(s), and attending physicians in the establishment, regular review, and implementation of interdisciplinary team care plans;
F. The requirements for providing documentation of services rendered in accordance with hospice program policy;
G. A requirement that all contracted services must comply with the standards contained in this Manual;
H. Compliance of the provider(s) with all applicable federal, state, and local regulations;
I. Liability and responsibility of the program and the provider(s);
J. The term of the agreement and the basis for its termination or renewal;
K. Provisions for reimbursement for services, if any; and
L. The individual(s) responsible for the implementation of the agreement's provisions.

3. If the hospice program, at the time of survey, is unable to provide a written agreement for the provision of home care and inpatient care services, there is evidence of at least the following:

A. A written plan to secure a written agreement for hospice services not currently provided directly, with supporting documentation of action taken on the plan;
B. The provision of interdisciplinary team care plans to the provider(s);
C. Provision for orientation and continuing education to identified personnel regarding pain and symptom management, psychosocial assessment and intervention, and the hospice philosophy of care;
D. Coordination of discharge and transfer planning;
E. Regular communication between the care providers and a designated hospice liaison, in accordance with hospice program policy, regarding the implementation and review of care plans; and
G. Twenty-four hour availability of hospice program consultation by interdisciplinary team members to the provider(s).

4. There is a written plan regarding the transfer or discharge of patients/families. The plan is applicable to program services whether or not provided directly and addresses at least the following:

A. The involvement of interdisciplinary team members who provide care;
B. The involvement of the patients/families in transfer or discharge decisions;
C. The instruction f the patients/families members, as appropriate, before discharge or transfer;
D. The delineation of the appropriate medical, clinical, and administrative information to be exchanged in a transfer as well as the method of exchange; and

E. Evidence of the attending physician's concurrence with the transfer or discharge plan, as indicated by his or her signature.

5. There is a policy in regard to communication between home care service and inpatient care service interdisciplinary team members regarding program issues, whether or not the services are provided by the program directly or under arrangement.

1st draft to committee 1-20-83

Chapter Six

Medical Records

GOAL ONE

An accurate medical record that provides documentation of hospice program services and is readily accessible to permit prompt retrieval of information is maintained for each patient/family.

RATIONALE

Significant patient-specific clinical information is found only in the medical record, and during the ongoing evaluation, diagnosis, and treatment of the patient, the patient/family medical record is depended on for the following:

- .Providing continuity of care between inpatient and home care services and evidence of communication among a number and variety of health care professionals involved in the care of the patient/family;
- .Providing a record of the patient's course to guide appropriate evaluation and treatment in response to the patient's condition and progress or lack of progress;
- .Providing information pertinent to the concurrent monitoring activities of the medical staff, interdisciplinary team members, and other hospice personnel; and
- .Providing information for use in continuing education activities, clinical research, clinical review activities of the medical staff, interdisciplinary team members and home care and inpatient services personnel, as outlined in the hospice quality assurance plan.

[illegible]

Upon termination of hospice care, the patient/family medical record becomes a historical document depended on for the following:

- .Providing information for use in the postdischarge care of the patient/family (if applicable);
- .Providing information to assist in protecting the legal interests of the patient/family, the hospice program, and the practitioner responsible for the patient's/family's care; and
- Providing information to validate charges for patient care services.

CHARACTERISTICS

1. There is a medical record for each patient/family served.

2. The medical record is sufficiently detailed and accurate to enable the assumption of care by any interdisciplinary team member.

3. There is a standardized medical record format designed according to the requirements of the hospice program. The format

   A. is used in both inpatient and home care services; and
   B. is used to document interdisciplinary team services.

4. The medical record of each patient/family provided hospice care includes, but is not necessarily limited to, the following:

   A. Data that identify the patient/family or an explanation for any missing items of identification;
   B. All pertinent diagnoses;
   C. The patient's prognosis;
   D. Designation of the attending physician(s);
   E. Designation of the family member or other primary caregiver to be contacted in the event of emergency or death;
   F. The patient's medical history, which may be a copy obtained from the hospital or physician's office, with an update added by the attending physician or hospice nurse;
   G. The findings of a physical examination by the attending physician performed within 24 hours upon admission to the inpatient care service;
   H. A current interdisciplinary plan of care that includes
      (1) a problem list,
      (2) a statement of goals and types and frequency of services to be provided, and
      (3) a statement of current medications, diet, treatment procedures, and equipment required;
   I. A description of the patient's functional limitations;
   J. A listing of the activities permitted;
   K. A listing of the safety measures required to protect the patient from injury;
   L. A physical assessment of the patient;
   M. A psychosocial assessment of the patient/family;
   N. For each home visit or inpatient service rendered, signed and dated progress notes that include
      (1) a description of signs and symptoms,
      (2) notations regarding treatment, service, or medication rendered and patient reaction,
      (3) notations regarding any change in the patient's condition, and
      (4) notations regarding any patient/family instruction as well as compliance with treatment;
   O. Legible and complete diagnostic and therapeutic orders authenticated by the attending physician;
   P. Relevant test determinations and procedure findings;
   Q. A record of interdisciplinary team conferences;

GOAL TWO

There is adequate supervision and staffing for maintaining medical records.

RATIONALE

The qualifications and commitment of the individuals who provide medical record services, and the effectiveness and efficiency of the systems used for collecting, storing, and retrieving pertinent clinical information, are major factors affecting the maintenance of high standards of patient/family care.

CHARACTERISTICS

1. The hospice program director appoints an individual to maintain medical records in accordance with hospice program policy.

   A. There are written requirements stating the minimum education and experience required for maintaining medical records.

2. Medical record services and personnel are directed, or at least reviewed twice annually on a consultative basis, by a medical record professional who has successfully completed the examination requirements of the American Medical Record Association or the equivalent.

3. The role of the medical record services in supporting the overall hospice program quality assurance program, the evaluation and monitoring activities of hospice services personnel, and the evaluation and monitoring activities of the medical staff (if there is a medical staff) is defined by the hospice program administration.

1st draft to Committee 1-17-83

Chapter Seven

Governing Body

GOAL ONE

An organized governing body is responsible for establishing hospice program policies, and for maintaining high standards of patient care and program management.

RATIONALE

In any organization, there must be a group that accepts ultimate responsibility and exerts ultimate authority.

CHARACTERISTICS

1. A private, independently owned, or community-agency-owned hospice program has a charter and/or constitution and bylaws and, where required, a state license.

2. The governing body is the individual, group, corporation, or government agency in which the ultimate responsibility and authority for the operation of the hospice program is vested.

3. A hospice program that is a component of another facility, institution, or government agency has a written description stating at least the following:

   A. The governing body responsible for the hospice program;
   B. The relationship of the governing body of the facility, institution, or agency to the director of the hospice program; and
   C. The authority given to the hospice program specific to

      (1) planning and organization,
      (2) program operation,
      (3) the hiring, termination, and assigning of hospice program personnel, and
      (4) policy and procedure adoption and review.

4. The governing body adopts bylaws in accordance with its legal accountability.

5. The bylaws include, but are not limited to, the following:

   A. The role and purpose of the hospice program;
   B. The duties and responsibilities of the governing body;

C. The method of selecting members of the governing body and the permissible length of members' service;
D. The method of selecting officers of the governing body and the permissible number of terms officers can serve;
E. The responsibilities of officers;
F. Meeting procedures, regularity of meetings, definition of "quorum" to conduct business, and attendance policy;
G. A list of the committees of the governing body and how they relate to the governing body;
H. The composition and responsibilities of the committees;
I. The mechanism by which bylaws are adopted and revised;
J. Provision for the regular review and revision of the bylaws and documentation of such action.

6. There is a defined and effective mechanism for communication between the governing body, the hospice program, the hospice administration, and the medical staff of the inpatient service.

7. The governing body provides for the establishment of auxiliary organizations, and approves the bylaws that delineate the purpose and function of such organizations.

8. Written records of the governing body's proceedings and the proceedings of each governing body committee is maintained and signed by a designated member of the governing body or committee, or by the secretary of the governing body.

9. Advisory-group committees or board membership reflect the involvement of members of the community served by the hospice program.

10. The capital budget and annual operating budget are adopted by the governing body, and implementation of these budgets is monitored.

11. The governing body appoints the hospice program director or designates that authority to the appropriate administrative representative in accordance with written institution or agency policy.

12. There is a defined mechanism for self-review and evaluation of the governing body's performance. The mechanism includes a statement of the regularity of the review and how it is initiated and analyzed.

13. The governing body reviews and approves the bylaws and the rules and regulations of the medical staff of the inpatient care service.

14. The responsibilities of the governing body are written, formally adopted, dated and available to all members of the governing body. The responsibilities include, but are not necessarily limited to, the following:

A. Approving of the hospice program's goals and objectives;
B. Evaluation of the program's performance with regard to its stated purpose, goals, and objectives;
C. Determining and approving of policies to govern the program;
D. Assuring fiscal solvency and adequacy of financial resources;

E. Planning for long-term development and maintenance;

F. Supporting a comprehensive quality assurance program; and

G. Providing the necessary support for implementing, and reporting the activities of, interrelated mechanisms of the home care and inpatient services for monitoring patient care and for identifying and resolving problems.

GOAL TWO

The governing body avoids conflict of interest.

RATIONALE

A governing body member whose decisions may be influenced by direct or indirect personal benefit may not be serving in the best interests of the hospice program and the community.

CHARACTERISTICS

1. There is full written disclosure of hospice program ownership and control.

2. The governing body develops and implements a written conflict of interest policy that includes the following:

   A. A description of the method and content of disclosure by governing body members;

   B. Guidelines for the resolution within a specific time frame, of any existing conflict of interest; and

   C. A defined ongoing mechanism for monitoring the conflict of interest policy and a specified time period for regular review of the policy.

GOAL THREE

The governing body provides for the orientation of its members.

RATIONALE

Orientation provides the means by which new governing body members can relate their expertise to hospice program functions and responsibilities and thereby participate in governing body discussions and decisions.

CHARACTERISTICS

1. An orientation is provided for each new governing body member and addresses at least the functions and responsibilities of the governing body and the history, services, and purpose of the hospice program.

Chapter Eight

Management and Administration

GOAL ONE

The hospice program is managed in a manner consistent with the authority and responsibility conferred by the governing body to accomplish program goals and objectives.

RATIONALE

The hospice program is a complex organization, and its management is responsible for using limited resources efficiently while maintaining high standards of patient/family care commensurate with currently available clinical knowledge and skills. The qualifications and commitment of individuals in management positions, as well as the effectiveness and efficiency of systems for supporting patient/family care, are essential to fulfilling these responsibilities.

CHARACTERISTICS

1. A qualified hospice program director, selected in accordance with hospice program or institution or agency policy, is responsible for operating the hospice program in a manner consistent with the authority conferred by the governing body.

    A. There are written requirements stating the minimum education and experience required for the position of hospice program director.

2. The hospice program director designates an individual to act in his or her absence.

3. The responsibilities of the hospice program director include, but are not necessarily limited to, the following:

    A. Implementation of the policies approved by the governing body;
    B. Effective utilization of personnel and resources to achieve program goals;
    C. Administration and evaluation of the program and interdisciplinary team services; and
    D. Participation with organizations that work to improve the care of the dying.

4. There are written policies and procedures to guide the hospice program director and the administrative staff in at least the following areas:

    A. The organization of programwide administrative functions, with clear delegation of duties, responsibilities, and lines of authority and accountability;

B. The establishment of the services needed for the efficient and effective functioning of the hospice;
C. Communication between program administration, the home care and inpatient care coordinator(s), interdisciplinary team members, and the governing body;
D. Compliance with applicable federal and state laws and regulations.
E. The establishment of internal controls to monitor the accuracy and reliability of data, and promote administrative efficiency;
F. The control of inventories, purchasing procedures, product selection and evaluation, and supply distribution;
G. The establishment of a administrative reporting system that provides understandable and standardized reports;
H. Protection and judicious use of the hospice program's physical resources;
I. The ongoing assessment of the community's hospice care needs;
J. Efforts to obtain community input and support of the hospice program;
K. The development of long-term and short-term program plans that reflect community hospice care needs; and
L. The development of evaluative reports on the efficiency and effectiveness and costs of hospice program service activities.

5. The hospice program director provides written plans to guide, and can confirm implementation of the personnel policies and procedures as stated in Chapter Nine of this <u>Manual</u>.

6. The hospice program director provides a written plan that states the method and frequency of reviewing all program and interdisciplinary team service policies and procedures at least annually. The plan addresses the following:

A. The appointment of a review committee by the hospice program director;
B. The composition and qualifications of the review committee;
C. The initiation of revisions of policies and procedures; and
E. Evidence of the annual review of the committee chairperson.

7. The hospice program director provides written fiscal policies and practices that address the implementation of at least the following:

A. An annual revenue and expense budget, with line items paralleling the hospice program's plan of organization;
B. A budgetary process in which at least the hospice program director, the home care and inpatient care coordinator(s), and the governing body participate;
C. An annual certified financial audit conducted by an outside accountant;
D. The control of accounts receivable and payable, the handling of cash, and the establishment of credit arrangements;
E. The preparation, in accordance with program policy, of comparative financial statements of budget versus actual revenue and expenses on an accrual basis; and
F. Reports on the nature and extent of available financial resources.

8. The hospice program director provides written plans to guide the collection and analysis of statistical data relevant to program evaluation, service utilization review, and problem-solving activities.

1st draft 12/28/82

Draft to committee 1-13-83

Chapter Nine

Personnel Policies and Procedures

GOAL ONE

Hospice program personnel policies and procedures are developed, adopted, and maintained. These policies and procedures promote the objectives of hospice services and provide for an adequate number of qualified personnel, during all hours of operation, to support the hospice services and provide high quality care.

RATIONALE

The qualifications of the individuals providing hospice program services, and the effectiveness and efficiency of the systems for collecting, storing, and reviewing pertinent personnel information, greatly affect the maintenance of a supportive, effective working environment and high standards of patient/family care.

CHARACTERISTICS

1. The hospice program director appoints an individual to be responsible for implementing and coordinating personnel policies and procedures and for maintaining personnel records.

2. There is a written organization plan for personnel services. The plan addresses at least the supervision of the processing of employment-related forms.

3. Personnel records are maintained in a manner that assures confidentiality and hospice program policy specifies who has access to various types of personnel information.

4. There are written policies and procedures that pertain to at least the following:

    A. Employee benefits.
    B. The recruitment and selection of employees. Hiring practices, which are written and are consistent with the needs of the hospice program, include at least
        (1) job-related criteria for selecting employees, and
        (2) a policy concerning the availability of bilingual personnel when people who speak languages other than English make substantial use of the program.
    C. Termination of employment.

D. Employee grievances and appeals procedures.
E. Safety.
F. Employee injuries and incident reports.
G. Wages, hours, and salary administration.
H. Rules of conduct.
I. Disciplinary systems.
J. Equal employment opportunities and affirmative action policies;
K. Liability insurance.
L. The acceptance of gratuities.
M. The determination that all personnel are medically capable of performing assigned tasks.

5. There are written policies and procedures that state the lines of authority and reporting of all hospice employees, including volunteers.

6. Personnel procedures are implemented to assure compliance with federal, state, and local laws related to employment practices.

7. There is written documentation to verify that the personnel policies and procedures apply to all hospice program employees and are explained and made available to each employee.

A. The policies and procedures are available to nonemployees upon request.
B. There is a mechanism for notifying employees of changes in policies and procedures.

8. There is written documentation of staff orientation initiated for each new employee before or during the first week of employment.

9. A personnel record is maintained for each hospice program employee and contains the following information:

A. The application for employment;
B. Documentation of both written and verbal references;
C. Verification of licensure, certification, and/or renewals;
D. Wage and salary information, including all adjustments;
E. Performance appraisals;
F. Initial and subsequent health clearances;
G. Counseling actions;
H. Disciplinary actions;
I. Commendations; and
J. Incident reports.

10. For each position in the program, there is a written job description that includes the following information:

A. The position title;
B. The department, service, or unit;
C. The direct supervisor's title;
D. If a supervisory position, the personnel supervised and degree of supervision;
E. The tasks and responsibilities of the job;

F. The minimum level of education, training, and/or related work experience required; and
G. Documentation of changes in qualifications, duties, and other major job-related factors.

11. There are written performance appraisals for each position in the program. An appraisal

A. is maintained in the employee's personnel record;
B. is related to the job description;
C. is conducted during the initial employment period;
D. is conducted at least annually after the initial employment period; and
E. contains documentation that the employee has reviewed the appraisal and has had an opportunity to comment on it.

12. The personnel service prepares an annual written report concerning its services and functions.

1st draft to committee 1-20-83

Chapter Ten

Utilization Review

GOAL ONE

The appropriate allocation of hospice resources is demonstrated through a utilization review program that includes the home care, inpatient care, and interdisciplinary team services.

RATIONALE

In striving to provide high-quality patient care in the most cost-effective manner, the administration of the hospice program needs information regarding the utilization of resources.

CHARACTERISTICS

1. A written plan that describes the utilization review program and governs its operations is implemented. The written plan is approved by the governing body and the hospice program director.

2. The written plan addresses at least the following:

   A. The appointment and composition of the utilization review committee which includes at least one representative each from the interdisciplinary team, home care, and inpatient services;
   B. The responsibility and authority of committee members;
   C. How the findings of the committee are interrelated with the quality assurance program;
   D. The frequency of committee meetings;
   E. The composition and dissemination of a report of the committee's findings at least annually;
   F. Procedures for conducting concurrent and retrospective reviews;
   G. A conflict-of-interest policy applicable to all review activities and, as determined by hospice program policy, to resultant findings and recommendations;
   H. A confidentiality policy applicable to all utilization review activities and to resultant findings and recommendations; and
   I. The mechanisms used to identify utilization-related problems.

3. At least annually, the utilization review committee reviews a defined number of medical records, selected randomly through a specific mechanism, to assess the appropriateness and adequacy of the services provided.

4. The mechanisms for identifying utilization-related problems include the following:

   A. Analysis of the appropriateness of admissions, continued stays longer than six months, home care versus inpatient services, and delays in provision of interdisciplinary team services; and
   B. Examination of the findings of related quality assurance activities and other relevant information.

5. The documentation of problem identification may include, but is not necessarily limited to, the following

   A. Profile analysis;
   B. Patient/family evaluation studies;
   C. Medication usage reviews; and
   D. Reimbursement-agency utilization reports that are service specific.

6. There is ongoing retrospective and concurrent monitoring of the utilization of home care, inpatient, and interdisciplinary team services.

7. The procedures for conducting concurrent review of hospice program services have the following characteristics:

   A. Specific time periods following a patient's admission to home care or inpatient services within which the review is initiated;
   B. Length-of-stay norms and percentiles used in assigning continued-stay review dates that are specific to home care or inpatient care;
   C. The utilization of factors other than, or in addition to, payment sources as the basis for determining which patients receive concurrent review; and
   D. Written measurable criteria and length-of-stay norms that are approved by the utilization review committee and the hospice program administration.

8. There is a written plan for initiating transfer from one hospice service to another or discharge from the hospice program when care is no longer needed or appropriate. The plan includes delineation of the responsibility for initiation and follow-through.

9. There is evidence that the findings and recommendations of the utilization review committee are the basis of action in the preceding twelve months in any one or more of the following areas:

   A. Patient services;
   B. Administration or supervision;
   C. Inservice or continuing education; and
   D. Compliance with regulatory or legal requirements.

10. There is evidence that the utilization review program, including the written plan, discharge criteria, and length-of-stay norms, is reviewed at least annually and revised as appropriate.

1st draft to committee 1-20-83

Chapter Eleven

Quality Assurance

GOAL ONE

The hospice program has a well-defined, organized quality assurance program designed to enhance patient/family care through the ongoing objective assessment of important aspects of care and the correction of identified problems.

RATIONALE

Hospice programs are complex organizations in which the results of patient/family care depend on the interrelated contributions of a variety of health care services and personnel. A major component of the interdisciplinary team's endeavors to deliver patient/family care that is optimal within available resources and consistent with achievable goals is the operation of a quality assurance program.

CHARACTERISTICS

1. The hospice program director designates a committee to implement and maintain the overall hospice program quality assurance program.

2. The quality assurance committee includes a representative from the hospice program administration, interdisciplinary team services, home care and inpatient services, and the medical staff of the inpatient service.

3. The type and frequency of all quality assurance activities in the hospice program are defined in a written plan which addresses at least the following:

   A. The development, adoption, and implementation of an individual quality assurance plan for <u>each</u> type of service--
      (1). bereavement services,
      (2). nursing services,
      (3). physician services,
      (4). psychological and social work services,
      (5). volunteer services,
      (6). home care services, and
      (7). inpatient services;

   B. The integration of findings from the monitoring, evaluation, and problem-solving activities of each quality assurance plan into the overall hospice program quality assurance program; and

   C. Delegation of responsibility for the implementation of and reporting for each quality assurance plan and the overall hospice program quality assurance program.

4. The findings of the individual quality assurance plans are reported, as defined in hospice program policy, to the governing body, the hospice program administration, and the coordinator(s) of the interdisciplinary team, home care, and inpatient services.

5. The individual quality assurance plans and the overall hospice program quality assurance program include at least the following components:

   A. Problem identification;
   B. Problem assessment;
   C. Problem correction;
   D. Problem monitoring; and
   E. Evaluation, documentation, and follow-up.

6. The quality assurance program includes identification of actual and/or potential problems or related concerns in the care of patients/families through at least the following sources of data:

   A. Findings of the quality assurance activities of each service;
   B. Utilization review findings; and
   C. Incident reports.

7. The quality assurance program includes objective assessment of the cause and scope of the problems and concerns identified. Problem assessment has the following characteristics:

   A. Prospective, concurrent, and retrospective assessment of the actual or potential problems identified;
   B. Adequate sampling of the services, disciplines, and individuals involved in the problems identified; and
   C. The use of written criteria that, when applied to actual practice, can result in measurable improvement in regard to patient/family care and clinical performance.

8. The quality assurance program incorporates methods for the implementation of decisions or actions designed to eliminate or reduce identified problems.

9. There is evidence that the recommendations of the quality assurance committee are the basis of action in the preceding twelve months in any one or more of the following areas:

   A. Administration or supervision;
   B. Inservice or continuing education; and
   C. Patient/family services.

10. The results of corrective actions taken are monitored periodically to assure that the identified problems have been eliminated or satisfactorily reduced. Finding suitable solutions to problems is a function and responsibility, as appropriate, of the governing body, the hospice program administration, the medical director, and/or interdisciplinary team members.

11. There is evidence that the individual quality assurance plans and the overall hospice program quality assurance plan are reviewed at least annually and revised as appropriate.

HOSPICE...... A COORDINATED PROGRAM OF HOME AND INPATIENT HEALTH CARE THAT PROVEDES OR COORDINATES PALLIATIVE AND SUPPORTIVE CARE TO MEET THE NEEDS OF A TERMINALLY ILL PERSON AND HIS FAMILY ARISING OUT OF PHYSICAL, PSYCHOLOGICAL, SPIRITUAL, SPCIAL, AND ECONOMIC STRESSES EXPERIENCED DURING THE FINAL STAGES OF ILLNESS AND DYING AND THAT INCLUDES FORMAL BEREAVEMENT PROGRAMS AS AN ESSENTIAL COMPONENT.

HISTORY OF HOSPICE

1967 Dr. Cicely Saunders, Medical Director of St. Christopher's Hospice, London admitted first hospice patient.

1974 New Haven Hospice, first in the United States, opened with state approval of their home care program.

1978 First Annual Hospice Meeting 75 hospice programs attended

1. Dr. Saunders stressed the need for standards and criteria to preserve the integrity of hospice
2. National Standards and Accreditation committee formed

1978 Dept. of Health, Education and Welfare funded 26 hospice demonstration projects to determine the efficacy of hospice care for terminally ill persons/families

1980 Specific Standards of Care were accepted at the annual meeting.

1981 Discussion of third-party reimbursement studied by NHO

1982 Admendment to the Medicare Act introduced and passed by Congress allows reimbursement for hospice care for Medicare recipients

Joint Commission on the Accrecidation of Hospitals (JCAH) presented standards to NHO meeting.

NHO membership endorsed JCAH standards of care

800 identified hospice programs nationwide.

SERVICES OF A HOSPICE PROGRAM

- 24 hours a day, 7 days a week on-call nurses for crisis intervention
- liaision between patient/family and physician
- coordination of appropriate community services
- control of distressing symptoms and pain
- respite for the person assuming the responsibility of care

PERSONS INVOLVED ON THE INTERDISCIPLINARY TEAM

patient and family members
patient's attending physician
hospice nurses, volunteers

others as needed such as:
social workers, counselors, clergy
physical therapist, dietician

LICENSING

April 1982... Nine states had some type of hospice-specific legislation
February 1983 Nine states had hospice-specific legislation pending

WHY LICENSING?

- The Federal govermnemt will begin reimbursing hospices for Medicare recipients Nov. 1083
- Montana Hospice providers anticipate that Federal standards for reimbursement will not allow the flexability which may be necessary to deliver care in a rural state.
- State licensing will assure quality of care in Montana by reviewing programs which may choose not to seek Medicare reimbursement.
- State licensing process includes a review of the need for service in a given area.

POSSIBLE STANDARDS MODELS

- National Hospice Organization Standards
- Joint Commission on the Accreditation of Hospitals Standards

Taken from newsletter yr [illegible]

SPECIAL FEATURE ARTICLE

ON... STANDARDS, ACCREDITATION, LICENSURE, AND REIMBURSEMENT

by: Daniel Hadlock, M.D.

When considering these terms as they relate to Hospice, one is not talking of the concept; one is talking of the program. Concepts are general, philosophic, non-specific. Programs are definable, service-oriented, specific. By virtue of the clarification.of meaning which occurs when one moves from the general to the specific, it should be no great surprise that those who think they agree in concept may find cause for disagreement when they seek to make the principles practical.

It has been suggested that the whole idea of making the hospice concept practical by setting standards and pursuing mechanisms of accreditation and licensure is inappropriate and impractical. I find such a suggestion unrealistic for three very practical reasons: (1) Without generally accepted standards, there can be no recognition of those characteristics that make hospice unique. When there is no common definition for a word or description of content for a program, then meaningful communication about such subjects become impossible because there is no consensus as to meaning. Thus, for its own credibility, Hospice must define itself or else the very word will become meaningless in practice. (2) Without an accreditation process based on such standards, there can be no assurance for the public or for other health care programs that there is quality or competence or consistency in the provision of Hospice care by the individual program. (3) Without licensure, hopefully based on standards and accreditation, there can be no expectation of appropriate reimbursement which would provide for the unique structure and process of Hospice program function. Financial security and consequent long-term viability for Hospice programs will be in doubt until this happens.

STANDARDS

In my three years on the Standards and Accreditation Committee of NHO, I worked with a number of persons commited to the concept of hospice. They came from a variety of professions, locations and programs. They began their work by examining the characteristics of existing Hospice programs which had set the example which triggered the hope that there really was a practical way to provide more appropriate care for the terminally ill. The resultant Standards of a Hospice Program of Care was endorsed by the Board of Directors of the NHO in February 1979, and by the membership-at-large in November 1979. (They are available at cost at the NHO offices.) The Standards were composed with one overriding concern--to outline the common characteristics of Hospice programs which had proven themselves in practice as being able to provide palliative care which met the total needs of the terminally ill and their families in both a competent as well as compassionate manner. Provided this patient need is met, the Standards allow leeway for a variety of organizational models. In themselves, the Standards are not sufficiently specific or measurable to qualify as an instrument for quality review (accreditation), licensure or reimbursement--nor were they meant to be. But they do establish a base on which to build these necessary evaluative procedures.

Five of these standards are truly unique in America, which is to say they are not currently accredited, reimbursed...or available. They are:

(1) The direct provision of care by an interdisciplinary team.
(2) Integrated, centralized administrative structure directly responsible for both inpatient and home care.
(3) 24-hour per day, 7-day per week availability of service.
(4) Medical director on staff.
(5) Bereavement care program.

If developing programs find it difficult to develop and provide such services, then they can recognize why such services are not routinely available. But Hospice standards were not written to describe what is convenient for the caregiver program; they were written to describe what is necessary for a program to have if it realistically expects to meet patient/family needs. If developing Hospice programs compromise their commitment to these ideals for the sake of expediency, then they have compromised the justification for their existence because they will not be any different from what already exists in the health care field.

ACCREDITATION

Consider the fantastic promise made in the name of hospice: total care, family support, around-the-clock service, coordinated inpatient and home care programs, grief and bereavement support, integrated professional and volunteer service, staff support programs, etc. Such care does not just happen; it requires a high degree of professional competence in both the administrative and in the health care fields as well as much human sensitivity and compassion on the part of all involved. For the protection of the public which seeks such care, for the the well-being and security of whose who would provide such care, for the maintenance of the good reputation the word "Hospice" currently enjoys, standards of reference need to be applied.

Accreditation is a voluntarily required application of a national standard, whereby a local program seeks out an objective assessment of itself by its peers and demonstrates its willingness to learn and improve itself in the process. The NHO is working actively to develop an accreditation process which is sensitive to the unique characteristics of Hospice programs, will measure not only structure and process but also outcome, and will be sufficient and nonduplicative of other accreditation efforts. Thus, Hospice programs will need only a single review instead of expending fees and staff time on a number of less comprehensive assessments and, hopefully, such review will be responsive to the needs of the Hospice program and assist in their development.

LICENSURE

Licensure is a state regulated process whereby the state determines whether the given health care program in its territory has the right to charge for service provided. Some states require that a Certification of Need be obtained first--to document that the program is providing a needed, nonduplicative service--before the program can apply for the review process necessary to obtain a license.

Reimbursement is essential for the long-term viability of Hospice programs, just as it is for any health care provider system. To be able to continue to provide for the needs of patients adequately means being able to provide for the security and peace of mind of the staff in the material as well as in the psychological and professional sense. Hospice "costs" in a variety of ways. If programs expect to be able to provide care "on the basis of need rather than the ability to pay", some ongoing mechanism of financial support is needed. And the reimburser is going to want some clear-cut definition of what it is they are paying for in terms of services, personnel, location of care, duration of service, etc.

Since licensure is a state regulated process, the appropriate organization to develop this process in each state is an organization of Hospice programs within that state. The NHO office is ready to advise and assist local Hospice programs in this area of endeavor. There are a growing number of states where Hospice legislative and/or regulations based on the Standards have been passed; these also would be good references and sources of assistance to the others when needed.

WASHINGTON REPORT ON
Medicine
& Health® PERSPECTIVES

JEROME F. BRAZDA, Editorial Director
KAREN GLENN, Editor

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HOSPICE: MEDICARE'S NEWEST PROVIDER

While Congressional budget cutters this year handed Medicare the largest reductions in its 17-year history, the lawmakers simultaneously voted to create a new provider under that same program. The bill to recognize hospice services as a benefit under Medicare was overwhelmingly approved. It offered Medicare beneficiaries with a terminal prognosis of six months or less the opportunity to be cared for in a hospice as an alternative to the traditional cure-oriented system. The timing for the bill was perfect. After three months of pre-election budget cutting, it gave Congress an image of generosity and in the process promised to save potentially sizable sums for the Medicare program.

Hospice legislation was introduced in the House (H.R.5180) and in the Senate (S.1958) in December 1981 by Rep. Leon Panetta (D-Calif.) and Sens. Robert Dole (R-Kans.) and John Heinz (R-Pa.). Hospice care as a Medicare benefit was signed into law as part of the 1982 Tax Equity and Fiscal Responsibility Act (P.L.97-248). Only two hearings were held, one by the House Ways & Means Health panel and one field hearing by the Senate Aging Committee. The speed with which the hospice bill found its way into law has caused some concern among both members of Congress and Administration officials who fear that demand for the new benefit will exceed the estimates and the potential savings will have been overstated. During budget conference deliberations last August, Sen. Russell Long (D-La.) remarked that the provision could be an "acorn that grows into a giant oak" in terms of costs to Medicare. Administration officials have voiced the same concern, comparing Medicare hospice coverage to the experience of Medicare's End Stage Renal Disease (ESRD) program. Patient load under ESRD grew from 18,000 in 1974 to 68,000 in 1981 at a cost of $1.5 billion. Opening up Medicare to hospices may also spark the development of for-profit hospices, critics charge, exploiting the hospice concept of care. The hospice movement in the United States traditionally has been characterized by nonprofit, community-based progams that rely heavily on home care and volunteers.

The concept of hospice care for the terminally ill has been around since the 1800s in Europe, but in the United States the movement is relatively new. The first hospice program began in Connecticut in 1974. In 1978 there were only 75 programs and by 1982 the number had soared to more than 800. The primary goal of hospice care is to keep the patient comfortable in a home-like setting and as free of pain as possible. Supportive care to both the patient and family is integral as is the interdisciplinary team approach. The Congressional Budget Office (CBO) estimates that there are about 50,000 persons being served by hospices annually; 95 percent are cancer patients and 60 percent are Medicare eligible; average lengths of stay vary from 35 days to 62 days. The Health

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Care Financing Administration (HCFA) has found that hospice care begins on average about 40 to 45 days before death.

In late June CBO sent Congress a cost analysis of the House bill, estimating that in 1983 every new hospice patient would save the Medicare program $1,120. If the patient were cared for in the hospital, cost per patient would be above $6,130, while hospice coverage would cost Medicare about $5,000 per user in 1983 including payments for some services currently provided by volunteers. The total cost, according to CBO, came to $105 per day for an average hospice stay of 45 days. During 1984, the first full year of the benefit, CBO estimated it would cost Medicare about $1 million, mostly the result of start-up costs. After that, the analysis showed increasing savings -- $16 million in 1985 and $40 million in 1986. The number of potential users came to 268,000 in fiscal 1984, but CBO estimated that only about 12,000 of them would be expected to use the new benefit in the first year.

DEMONSTRATIONS

A hospice demonstration project supported by HCFA, the Robert Wood Johnson Foundation, and the John A. Hartford Foundation got under way in the fall of 1980. Twenty-six demonstration project sites, 12 based in the community and 14 in hospitals, were given waivers and reimbursed by Medicare. The project addressed differences in costs and patterns of care between hospices and more traditional treatment as well as quality of life issues. Brown University is evaluating the project for HCFA and the results are due at about the same time that HCFA is to publish the final rules implementing the new hospice benefit and three months before the benefit formally begins. Preliminary data from the project currently is being used by HCFA in developing the hospice regulations.

The health insurance industry has endorsed the hospice concept of care and several groups are experimenting with a benefit plan. Among them is the Blue Cross and Blue Shield Association, which has been an enthusiastic supporter of hospice care. Thirty-five separate plans currently offer hospice coverage, usually through an existing home health or inpatient benefit plan. The association has concluded that the most successful programs organize local community resources and augment existing services only when necessary. Blue Cross has also found that costs for programs that rely primarily on inpatient care come close to costs for traditional health care for the dying.

THE NEW LAW

CBO's projected savings was the catalyst needed to push the hospice bills through Congress. At about the same time the National Hospice Education Project took to Capitol Hill. The House Ways & Means Committee included Panetta's bill in its 1983 tax-budget legislation and Heinz added the benefit to the Senate bill. Under the benefit, which will begin November 1983, all Medicare beneficiaries who are diagnosed as "terminal" with a life expectancy of six months of less will be able to elect hospice services. In opting for the benefit, beneficiaries must waive all other regular Medicare benefits except those of the attending physician. Two 90-day and one 30-day periods of care are covered, giving the patient the option to drop hospice care and return to the traditional Medicare covered service package.

Hospices must provide a "core" of services including nursing care, medical social services under the direction of a physician, physician services, and bereavement, dietary, and nutritional counseling. Bereavement counseling for family members, although required under law, will not be reimbursed. Noncore services such as inpatient care, respite care, home health aide or homemaker services, medical supplies, drugs, and therapy can be contracted out. However, hospices must retain management responsibility of all hospice care regardless of where that care is provided. The law does not allow the total number of inpatient days to exceed 20 percent of the aggregate number of all care days for hospice progams, so there is a strong home health care bias.

In an attempt to control costs, several co-payments were required. Patients must pay 5 percent of hospice costs for outpatient drugs or $5, whichever is less. There is a co-payment of 5 percent of hospice costs for inpatient respite care that, under the law, is not to exceed the hospital inpatient deductible applicable for the benefit period. Originally, the bills set reimbursement at 75 percent of average Medicare costs for treating patients with cancer. However, CBO found that the 75 percent average was much too high, about $11,000, and a 40 percent limit, estimated at $5,840, would come closer to the actual cost.

Broadly defined in the law, a hospice can be either a public or private group or subdivision of such a group as long as it provides care on a 24-hour basis, provides bereavement care, employes an interdisciplinary team, provides or supervises hospice services, and is licensed according to state laws. Eleven states currently have such laws. Because the hospice concept in this country relies heavily on the work of volunteers, Congress required that a hospice program use volunteers and maintain records on cost savings through their use. Within these requirements, hospitals, nursing homes, and home health agencies, nonprofit and proprietary, have the opportunity to begin programs.

Congress gave HCFA until September 1983 to publish final rules setting hospice standards and the reimbursement methodology. In order to meet that deadline, HCFA plans to have a notice of proposed rulemaking published early this winter and some 40 staff members have been assigned to that task. The lure of federal funds and the complexities of federal regulations have some critics of the benefit concerned about the future of the hospice movement. Some worry that hospitals or nursing homes will simply label a wing as a hospice. However, proponents say that Congress built in enough guidelines and safeguards. Even so, the future shape of the hospice program may well be determined by how strictly HCFA interprets the guidelines. Even the seemingly simple task of defining a hospice becomes problematic. HCFA faces three major strategic issues in developing the regulations: payment methodology, the requirements for facilities providing inpatient care, and the responsibilities of a hospice, particularly maintaining "professional management responsibility" for services it does not provide directly. Still another issue is what role, if any, JCAH will play. JCAH recently completed a hospice accrediting standards manual and JCAH's board will be voting next month on whether to go into the hospice accrediting business.

Although the legislation established a cap on total reimbursement, it also gives HHS the flexibility to design a method for reimbursing hospices. The cap does not include a length of stay adjustment nor does it include the services of a patient's attending physician unless the physician is employed by the hospice. The cap may therefore not be an effective reimbursement control. Two of the reimbursement options being considered by HCFA are a prospective plan and a reasonable cost reimbursement system. In developing a prospective plan, HCFA must decide whether to go with a per capita or per case basis, per diem, or a separate per diem for each level of service. Some have argued, however, that because of insufficient data and the unique settings for hospice care, a prospective system would be difficult to develop and implement. HCFA officials indicate, however, that the most effective long term reimbursement control may be prospective payment and, since costs may well determine whether hospice survives as a Medicare benefit, HCFA may not have any choice.

One of the most difficult, and hotly debated issues between hospices and other providers are the regulations that will define the term "professional management responsibility." Hospices must retain this responsibility for services it has arranged regardless of where the services are furnished. Hospices that are not based in hospitals may have some difficulty establishing arrangements for hospital care. This could become a justification for hospices to construct their own freestanding inpatient units, rather than using the services of hospitals and nursing homes within the community. Another question is who becomes legally liable once a patient is admitted to an inpatient facility. One solution would be to allow the attending physician who had participated as part of the hospice team to admit the patient and retain management responsibility. Opponents fear that the admitting physician may not be committed to the hospice concept and the hospice would in effect be surrendering its control of patient care. In this situation, however, hospices would not have to make formal arrangements with hospitals for inpatient care. The other alternative would be to require the hospice itself to retain control in all settings. Although this option may encourage hospices to build freestanding inpatient units, payment could be controlled more tightly because all reimbursement will flow through the hospice.

Since hospices are required to provide inpatient care, HCFA must also establish the conditions under which those providers can participate in the program and how the standards will relate to other federal requirements for facilities already certified to participate in Medicare. Hospices will be given separate provider status but the legislation directs HHS to coordinate existing standards for multiple providers. The question then becomes how to write the regulations so that they are not duplicative or contrary to existing requirements while developing the most efficient way for hospices to relate to other providers. The degree to which hopitals and nursing homes participate and how the hospice program will be integrated into the existing provider community may largely be determined by these decisions. Even with the safeguards built into the law, HCFA has been given considerable discretion and flexibility. If the findings from the HCFA demonstration project vary considerably from the assumptions used to write the law, Congress has built in an important safeguard -- a sunset provision that stops the hospice benefit in November 1986 unless Congress votes to continue it. It is clear that the hospice concept of care is rapidly becoming a part of the nation's health care system. However, in light of this Administration's budget cutting philosophy, it is something of an anachronism that hospice found its way into a federal program so quickly.

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Hospice movement growing, but care standards needed

By Martha Lemke
Executive Director
Hospice of Greater Portland

With the explosion of hospice programs around the United States (from seven programs in 1976 to an anticipated 800 + by the end of this year), attention has been focused more and more on the need for standards of care.

The impetus for standards development are three-fold:

1. To guide the development of new programs;
2. To guarantee to the public some level of quality services; and
3. To qualify programs for reimbursement.

Standards development in Oregon began in 1979 with passage of a bill by the Oregon Legislature which established a task force to consider the questions of standards, licensure, regulation, and accreditation. This task force recommended:

1. That accreditation is the most appropriate level of hospice regulation;
2. That a continuing advisory committee on hospice care be established under the auspices of the Health Division; and
3. That the Health Division should draft enabling legislation to implement the advisory committee.

H.B. 2085 was introduced in the 1981 Session at the request of the Oregon Council of Hospices. This bill would have provided for the advisory committee. It failed to pass — not because the Legislature did not like the idea (support for hospice was encouraging), but because there were no public funds to underwrite the effort.

In spite of this discouragement, the Oregon Council of Hospices felt strongly the need to pursue local development of standards and to encourage accreditation. With full support from the Council and dedicated volunteer efforts by Council members, the process began.

First, the Council became the central core of the Advisory Committee on Hospice Accreditation, set up by the State Health Division at the request of the Council. Next, a discussion draft was written and circulated for comment to all persons and organizations affected by or interested in such standards. Currently, a second draft is being readied for review.

The intent of the standards and voluntary accreditation is to encourage the highest quality of hospice care. Accreditation standards list criteria which define optimal care to the patient and family, whenever care is given, or from whatever type of hospice or administrative setting the care is provided.

The accreditation process will reflect the interdisciplinary nature of hospice care and promote education, consultation, and collaboration.

The Oregon Council of Hospice assumes responsibility to accredit hospice programs in the state of Oregon. In addition, the Council will maintain a registry of programs which are accredited. To accomplish the process of accreditation, the Council was recently awarded a major grant from the Episcopal Diocese of Oregon.

The timetable is as follows:

June-July, 1982 – Circulation and adoption of second draft of standards, and development of a survey instrument.

August – Field Test.

September – Revision.

October – Adoption of standards and accreditation process by the Council.

December 9 and 10 – Training of hospice surveyors.

January, 1983 – Initiate voluntary accreditation of Oregon programs.

The goal in Oregon is to make hospice care available through organizations governed, managed, and staffed by people committed to the fundamental precepts of the hospice philosophy. The standards being developed will further that goal by providing a model for development of programs.

Cancer nursing grants announced

The Oregon Nurses Cancer Education Program (ONCEP) announces a scholarship fund available to any student interested in enrolling in ONCEP courses who is in need of financial assistance. Grants will be limited to $50, and in most cases only one grant will be available to any student in a calendar year.

Applications will be reviewed by a scholarship committee consisting of one staff member, one executive committee member and one ONCEP student. Grants will be made as quickly as possible after the initial January 1, 1983, deadline for applications. For information regarding application, please call 225-7338.

Money for these scholarships came largely from contributions to three funds:

a) Honoraria given to Charlotte Wright, R.N., M.N., and donated by her for scholarship assistance;

b) A memorial fund established for the late Mary Lou Howbert, M.D., who was instrumental in the development of some of ONCEP's initial course offerings; and

c) Funds given to Patsy DeMent, R.N., by patient families and donated by her for ONCEP scholarships.

Because of current economic conditions, many students are having difficulty continuing in the program. Additional contributions to the scholarship fund will be welcome.

Patient cost limits use of esoterica –

– Continued from page 3

ally manage such tumors very economically.

Ultimately, patient cost will determine the success or failure of these very high-energy charged particles. For now, the cost is out of reach.

Summary

This brief review has cited the contribution of technological advances to 86 years of progress in the art/science of Radiation Oncology. Current investigations, such as those described above, give promise to continued growth.

Today, in a well-equipped and well-staffed radiation therapy clinic, cancer patients can expect a reasonable chance of cure – or at least local control of their disease – with treatment side effects that are for the most part quite tolerable.

HIGHLANDS
HOSPICE, Inc. P.O. Box 267, Butte, MT 59703

NATIONAL HOSPICE ORGANIZATION

STANDARDS OF CARE

NATIONAL HOSPICE ORGANIZATION

STANDARDS OF A HOSPICE PROGRAM OF CARE

ADMINISTRATION

Principle:

The health care delivery system, of which a hospice program is an integral part, is regulated by local, State and Federal law. In order to provide care in this system, a hospice program must meet the fundamental requirements for operation and delivery of service.

Standard 1: The hospice program complies with applicable local, State and Federal law and regulation governing the organization and delivery of health care to patients and families.

CONTINUITY OF CARE

Principle:

Hospice patients and families may experience a considerable degree of fragmentation and alienation. Hospice maintains that continuity of care (including both services and personnel) reduces the sense of fragmentation and alienation. "Continuity" implies the capacity to respond to patient/family needs whenever they arise. It also implies enough administrative and staff integration to ensure continuation of the same high quality care when the patient moves from home to inpatient unit or vice versa.

Standard 2: The hospice program provides a continuum of inpatient and home care services through an integrated administrative structure.

Standard 3: The home care services are available 24 hours a day, seven days a week.

PATIENT/FAMILY AS THE UNIT OF CARE

Principle:

Inclusion of the family in the hospice care program is essential. The wishes and desires of the patient/family are of central importance in developing the care plan. The family members are seen both as primary caregivers and as needing care and support so that their own stresses may be attended to. Attention is also paid to developing a quasi-family support network when relatives are not available and a patient needs and wants that support.

Standard 4: The patient/family is the unit of care.

Standard 5: The hospice program has admission criteria and procedures that reflect:

A. The patient/family's desire and need for service

B. Physician participation

C. Diagnosis and prognosis

The hospice program encourages family participation in patient care and provides support for them.

Standard 6: The hospice program seeks to identify, teach, coordinate and supervise persons to give care to patients who do not have a family member available.

Standard 7: The hospice program acknowledges that each patient/family has its own beliefs and/or value system and is respectful of them.

PERSONNEL

Principle:

The amount and type of care is based on need, as established with the patient and family. Care is provided by an interdisciplinary staff which includes at least the following qualified personnel (core team): Patient and patient's family, physician, nurse, social worker, volunteer, clergy. The team is coordinated by a qualified health care professional. The team meets regularly to develop and maintain an appropriate plan of care and to determine which staff members will intervene and work together in a situation. Regular staff support, education and training are also provided, based on a recognized need.

Standard 8: Hospice care consists of a blending of a professional and nonprofessional services, provided by an interdisciplinary team, including a medical director.

Standard 9: Staff support is an integral part of the hospice program.

Standard 10: Inservice training and continuing education are offered on a regular basis.

SYMPTOM CONTROL

Principle:

Hospice programs recognize that when a patient and family are faced with terminal disease, stress and concerns may arise in many aspects of their lives. Optimum symptom control includes addressing those stresses and concerns, in addition to the use of appropriate therapies. This therapy may be a blend of curative and palliative treatments that produce the greatest degree of relief from stress caused by disease for the longest period of time, with the least undesired side effects.

Standard 11: The goal of hospice care is to provide symptom control through appropriate palliative therapies.

Standard 12: Symptom control includes assessing and responding to the physical, emotional, social and spiritual needs of the patient/family.

BEREAVEMENT

Principle:

Grief and bereavement are normal reactions to loss and death. Grief is the highly personal response to loss; bereavement is the extended period of deprivation following the loss of a loved one. Grieving may precede an anticipated death or may be delayed for a considerable time. Grief may manifest itself in emotional and/or physical distress and may affect different family members in different ways at different times. Death of a family member can result in a wide range of physical, emotional, social, familial, economic and spiritual disruptions. Some persons can resolve grief with time and their own available resources; others may require formal assistance and support over an extended period of time.

Hospice work includes attention to needs of the bereaved, to assessment of needs of the bereaved, both before and after a death, and to the development of programs and resources to meet the needs of the bereaved. Hospice encourages the expression of grief, recognizes social/religious and ethnic variables in bereavement and supports staff and family participation in meanful funeral services and rituals.

Standard 13: The hospice program provides bereavement services to survivors for a period of at least one year.

QUALITY ASSURANCE

Principle:

Hospice is committed to developing and utilizing methods to measure and assure quality of patient/family care.

Standard 14: There will be a quality assurance program that includes:

A. Evaluation of services

B. Regular chart audits

C. Organizational review

RECORDS

Principle:

Documentation of services is necessary and desirable in the delivery of quality care. Therefore, a hospice record of care will be maintained in order to insure compliance with regulatory and quality care standards. Of critical importance is the development of an integrated chart which records the assessments and proposed interventions by all interdisciplinary team members for the patient as well as for the family.

Standard 15: The hospice program maintains accurate and current integrated records on all patient/families.

PHYSICAL PLANT

Principle:

Not all patients can be maintained at home; some require inpatient services. The hospice inpatient unit reflects the unique nature of hospice care, and provides for special needs of the dying and their families.

Standard 16: The hospice complies with all applicable State and Federal regulations.

Standard 17: The hospice inpatient unit provides space for:

A. Patient/family privacy

B. Visitation and viewing

C. Food preparation by the family

GLOSSARY

appropriate - especially suitable or compatible; fitting.

bereavement - the period of time during which a person or group of people experiences, responds emotionally to, and adjusts to the loss by death of another person. Hospice is attendant particularly to the acute phase of the bereavement process, usually occurring within the first year after the loss.

care - to perceive and respond to the needs of another.

clergy - the body of persons ordained for religious service.

continuum - the uninterrupted provision of services appropriate to the needs of the patient and family; these services are planned, coordinated, and/or made available by the Hospice program.

coordinate - to organize and manage the efficient utilization and interaction of multiple resources.

core team - the essential members of the core team include the patient and family unit, physician, nurse, social worker, clergy, and volunteer who work together as an interdisciplinary team to provide Hospice care.
Note: the physician on the core team may be the primary physician and/or the Hospice physician.

family - a group of individuals living under one roof and under one head; a group of persons of common ancestry; a group of individuals having a common commitment one to the other.

grief - response to loss that often occurs in stages of varying length. These stages are differentiated by changes in feeling, throught, and behavior following loss. The stages can but do not always occur in a predictable order.

interdisciplinary - a term describing the Hospice team, indicating that the team members, representing the core disciplines and other related disciplines, interrelate in an effective working relationship enabling the provision of Hospice services to Hospice patients and their families.

licensed - persons authorized to practice in the professional discipline for which they have been prepared by the licensing authority having jurisdiction in the state of their operation.

limited prognosis - the disease state that has minimal chance of reversal and for which the remaining life span is estimated to be six months or less.

medical director - that licensed medical practitioner (salaried or not) on the Hospice [illegible] identified by [illegible] Hospice [illegible] as having ultimate responsibility for medical aspects of hospice care. This individual can be directly or indirectly involved in actual patient care.

nurse - a graduate registered professional in the nursing field who is involved with the determination and delivery (directly or in an advisory capacity) of nursing aspects of Hospice care to patients and families on the Hospice program.

nursing - is primarily assisting individuals (sick or well) with those activities contributing to health or its recovery (or a peaceful death) that they perform unaided when they have the necessary strength, will or knowledge; nursing also helps individuals carry out prescribed therapy and to be independent of assistance as soon as possible. (Henderson, Virginia: Principles and Practice of Nursing, sixth edition, Macmillan Publishing Company Co., Inc., 1978, p. 14.)

nursing service - pertaining to the curative, rehabilitative, and preventative aspects of nursing care that are planned, performed, supervised, and/or directed by a registered professional nurse (from the Classification of Health Care Institutions, published by the American Hospital Association, 1974).

palliative treatment - the primary dictionary meaning of the term "to palliate" is "to reduce the violence of: abate." In the Hospice context, it means the reduction or abatement of pain and other troubling symptoms by appropriate coordination of all elements of care needed to achieve relief from distress.

physician, attending - any licensed medical practitioner identified by the patient and family as having a significant role in the determination and delivery of medical care while on the Hospice program. This individual usually would be the primary physician, but would not usually be part of the Hospice staff.

physician, consulting - any licensed medical practitioner asked by medical practitioners already treating a patient and family to provide limited medical advice and therapy for the specific needs of a patient or family. Such care is provided under the coordination of the requesting physician, who may or may not be on the Hospice staff.

physician, Hospice - any licensed medical practitioner on the Hospice staff (salaried or not) who is involved with the determination and delivery (directly or in an advisory capacity) of medical aspects of Hospice care to patients and families on the Hospice program. This individual may or may not be the patient's primary physician.

physician, primary - that licensed medical practitioner whom the patient and family identify as having the most significant role in the determination and delivery of medical care to the patient at the time of referral to and acceptance on the Hospice program. If this physician is not on the Hospice staff, the physician's consent will be necessary for admission of the patient to the Hospice care program.

plan of care - the orderly and detailed design and method [illegible] condition and taking responsibility for another -- in this case, the patient and family [illegible]

GLOSSARY (continued)

primary care person - that member of the family who is designated by the patient and the Hospice care team as the chief or leading giver of care to the patient at home.

record - a written documentation that accurately reflects all elements of patient care including assessment, planning, intervention, and evaluation.

social work - the professional activity of helping individuals, groups, or communities enhance or restore the capacity for social functioning and creating societal conditions favorable to this goal. Social work practice consists of the professional application of social work values, principles, and techniques to one or more of the following ends: helping people obtain tangible services; psychotherapy with individuals, families, and groups; helping communities or groups provide or improve social and health services; participating in relevent legislative processes. The practice of social work requires knowledge of human development and behavior; of social, economic and cultural institutions and of the dynamics of the interactions of all these factors. (National Association of Social Workers).

social worker - one who possesses a master's degree in social work from a college or university accredited by the Council on Social Work Education. Hospice social work services may be managed or delivered by a person possessing a bachelor's degree in social work from a college or university accredited by the Council on Social Work education as long as that person maintains a regular, ongoing, consultative relationship with a graduate social worker.

special needs - those requirements which are particular to the situation or condition of a Hospice patient and family.

special services - those services not represented on the core team that may be valuable for specific patient and family needs, including but not limited to, home-makers, home health aides, recreation therapists, occupational therapists, respiratory therapists, pharmacists, dieticians, lawyers, certified public accountants, funeral directors, musical therapists, art therapists, speech therapists, physicial therapists. The motivation for inclusion of such services is to enhance the patient's and family's abilities to deal with the special stresses of specific situations.

standard - an authorized principle or rule that usually implies a model or pattern for guidance by comparison with which the quality, excellence, or correctness of other things may be determined.

terminally ill - experiencing an illness for which therapeutic strategies directed toward cure, outside the context of symptom control, are no longer appropriate; expected survival of six months of less.

unit of care - who it is that is to receive Hospice services; since the term "unit" means a single, whole "thing," Hospice defines the patient and family to be the single whole, regardless of the degree of harmony or integration of the parts within that whole.

volunteer - that lay or professional person who contributes times and talent to the Hospice program without economic remuneration.

NAME: Lynn A. James DATE: 2-2-83

ADDRESS: Box 143 Star Rt. Clancy, Mt. 59634

PHONE: 443-0016

REPRESENTING WHOM? Hospice of St. Peters

APPEARING ON WHICH PROPOSAL: Senate Bill #208

DO YOU: SUPPORT? ✓ AMEND? ____ OPPOSE? ____

COMMENTS:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

NAME: Hazel C. Murray DATE: 2/3/83

ADDRESS: 100 Short Drive Helena, Mt. 59601

PHONE: 442 2086

REPRESENTING WHOM? Hospice of St. Peter's

APPEARING ON WHICH PROPOSAL: S.B. 208

DO YOU: SUPPORT? X AMEND? ____ OPPOSE? ____

COMMENTS: Support S.B. 208 For licensing of Hospice. Give this support as an active volunteer of Hospice of St. Peter's. Speak from a background of 30^{+} years in health care field. (Retired R.N. - MN & post grad. work in administration)

Hazel C. Murray

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Hospice of Helena
Exhibit 3

ROLE OF THE VOLUNTEER

THE FIRST VISIT IS ALWAYS HARD. "WILL THEY LIKE ME?" "WILL I BE ABLE TO HELP?" "WHAT WILL I DO?" THESE QUESTIONS ARE NATURAL. JUST REMEMBER AT THESE TIMES THAT YOU HAVE BEEN SELECTED TO SERVE AS A HOSPICE TEAM MEMBER BECAUSE PEOPLE EXPERIENCED IN THE FIELD HAVE CONFIDENCE IN YOU. JUST 'PLUNGE IN' TAKING WITH YOU AN ATTITUDE OF OPENNESS AND RECEPTIVITY TO THE NEEDS OF THE PATIENT/FAMILY TO WHOM YOU HAVE BEEN ASSIGNED. THEY WILL LET YOU KNOW WHAT THEY NEED, AND YOU, IN TURN, WILL LET THEM KNOW WHAT YOU CAN OFFER. THE RELATIONSHIP UNFOLDS STEP BY STEP IN A VERY NATURAL WAY.

HERE ARE SOME GUIDELINES THAT MAY HELP:

1) <u>GENUINENESS</u> - BE YOURSELF. ASIDE FROM MODIFICATIONS IN BEHAVIOR TO ASSURE THE COMFORT OF THE PATIENT, I.E., QUIETNESS, LESS TALKING AND MORE LISTENING, CONSCIOUS ATTENTIVENESS, ETC., THE VOLUNTEER SHOULD RELATE WITH THE SAME 'PERSONALITY' HE DISPLAYS IN OTHER SITUATIONS. PEOPLE WHO ARE ILL APPRECIATE BEING TREATED NATURALLY, AND IN THIS WAY ARE REASSURED THAT THEIR ILLNESS HAS NOT SET THEM APART ANY MORE THAN IN THE OBVIOUS WAYS. RELATE TO THE PATIENT, NOT THE ILLNESS.

   THIS HOLDS TRUE FOR FAMILY MEMBERS AS WELL. THE VOLUNTEER ROLE IS THAT OF FRIEND AND SUPPORTER, NOT EXPERT OR AUTHORITY. YOU ARE NOT EXPECTED TO KNOW ALL THE ANSWERS. IT DOES NOT TAKE LONG TO CLARIFY FOR THE FAMILY THAT MEDICAL AND TECHNICAL QUESTIONS CAN BEST BE ANSWERED BY THE NURSE AND PHYSICIAN, AND THAT YOU ARE THERE TO FACILITATE THIS COMMUNICATION AND TO PROVIDE OTHER, LESS TECHNICAL SUPPORT. THIS ROLE DEFINITION COMES ABOUT MOST EASILY WHEN THE VOLUNTEER FEELS COMFORTABLE FROM THE BEGINNING JUST BEING HIMSELF.

2) COMMUNICATION WITH NURSE - THE IMPORTANCE OF CLEAR COMMUNICATION BETWEEN NURSES AND VOLUNTEERS CANNOT BE OVEREMPHASIZED. THE TWO OF YOU ARE A MINI-TEAM AND CAN BE OF GREAT HELP TO ONE ANOTHER AND TO THE PATIENT/FAMILY BY MAINTAINING REGULAR CONTACT AND KEEPING ONE ANOTHER CURRENT WITH WHAT IS GOING ON. DON'T BE AFRAID TO TAKE THE INITIATIVE IN ESTABLISHING THIS RELATIONSHIP; IT IS IMPORTANT TO BREAK THE ICE EARLY SO THAT A STRONG BOND CAN BE ESTABLISHED BEFORE THE PATIENT/FAMILY'S SITUATION COMES A CRISIS. EXCHANGE SCHEDULES AND APPROPRIATE PHONE NUMBERS AND CLARIFY MUTUAL EXPECTATIONS WITH ONE ANOTHER AT THE START. A WORKING RELATIONSHIP IS ESSENTIAL TO MAINTAINING CONTINUITY AND STABILITY, AS WELL AS TO PROVIDING QUALITY CARE.

3) <u>COMMUNICATION WITH THE FAMILY</u> - IT IS YOUR RESPONSIBILITY TO STATE CLEARLY TO THE FAMILY WHAT YOU CAN AND CANNOT OFFER IN TERMS OF TIME AND AVAILABILITY. THIS WILL PREVENT AWKWARD AND POSSIBLY PAINFUL MISUNDERSTANDINGS AT ANOTHER TIME. IT IS HELPFUL TO ASK THE FAMILY TO OUTLINE THEIR NEEDS AND EXPECTATIONS AT THE BEGINNING (WITH THE STATED UNDERSTANDING THAT THESE MAY CHANGE AS THE PATIENT'S CONDITION CHANGES), AND TO INDICATE HOW YOU CAN HELP FILL THESE NEEDS, GIVEN YOUR OWN LIFE PATTERN. REGULAR PHONE CALLS TO 'CHECK IN' ARE OFTEN APPRECIATED, AND SOMETIMES RESULT IN MEANINGFUL AND SUBSTANTIVE CONVERSATIONS. SOME PEOPLE FIND IT EASIER TO OPEN UP IN AND UNPLANNED PHONE CONTACT THAN DURING A SCHEDULED VISIT. AGAIN, IN MOST INSTANCES, IT IS UP TO YOU TO TAKE THE INITIATIVE IN GETTING THINGS GOING.

4) DEPENDABILITY - TO PEOPLE IN CRISIS, WHOSE LIVES ARE SUBJECT TO SO MUCH UNPREDICTABILITY, IT IS ESSENTIAL TO KNOW THAT THEY CAN COUNT ON SOMEONE OR SOMETHING. NEVER OFFER MORE THAN YOU KNOW YOU CAN DELIVER. THE LIFE OF A SERIOUSLY ILL PERSON HAS LITTLE VARIETY AND FEW DISTRACTIONS AND THEREFORE EACH OUTSIDE CONTACT ASSUMES LARGER THAN USUAL PROPORTIONS AND IMPORTANCE. WHAT MAY BE A MINOR PART OF YOUR WEEK MAY BE THE SINGLE EVENT THAT THE PATIENT HAS BEEN EAGERLY AWAITING FOR DAYS. IT MAY ALSO BE AN OPPORTUNTIY FOR THE PRIMARY CARE-GIVER TO HAVE SOME PRIVATE TIME AWAY FROM THE RESPONSIBILITIES OF PATIENT CARE.

5) LISTENING - ALWAYS REMEMBER THAT YOUR FUNCTION AS A VOLUNTEER IS TO FIRST MEET THE NEEDS OF YOUR PATIENT/FAMILY, RATHER THAN YOUR OWN. IN MOST INSTANCES THIS MEANS LISTENING MORE THAN TALKING. IT MAY MEAN LISTENING TO THE SAME STORIES OVER AND OVER AGAIN - STORIES THAT FOR WHATEVER REASON SATISFY A NEED OF THE PATIENT OR THE FAMILY MEMBER IN THE TELLING. IT MAY MEAN LISTENING NON-JUDGEMENTALLY TO OUTBURSTS OF ANGER, FRUSTRATION, AND RESENTMENT, WHICH SERVES TO RELEASE TENSION. YOU MAY EVEN BE THE TARGET FOR SOME OF THESE NEGATIVE FEELINGS. DON'T TAKE IT PERSONALLY. PEOPLE UNDER SEVERE STRESS OFTEN ACT INAPPROPRIATELY.

6) CONFIDENTIALITY - REFERENCES TO THE PATIENT/FAMILY SHOULD BE CONFINED TO CONTACTS WITH THE HOSPICE TEAM, EITHER INDIVIDUALLY OR AT MEETINGS. INFORMATION OF EXTREME CONFIDENTIALITY DIVULDGED BY A PATIENT OR FAMILY MEMBER SHOULD NOT BE SHARED IN A GROUP SESSION UNLESS IT BEARS DIRECTLY UPON THE DESIGNING OF A CARE PLAN. SUCH INFORMATION MAY BE SHARED WITH THE INDIVIDUAL TEAM MEMBERS, HOWEVER, IF NEEDED FOR THE PEACE OF MIND OF THE VOLUNTEER.

AT NO TIME SHOULD A VOLUNTEER PROMISE 'NOT TO TELL ANYONE' ANY PIECE OF INFORMATION ALLUDED TO BY A PATIENT OR FAMILY MEMBER. IT IS FOR THE PROTECTION OF BOTH THE PATIENT/FAMILY AND THE VOLUNTEER THAT THE VOLUNTEER BE ALLOWED TO USE HIS DISCRETION AS TO WHETHER INFORMATION NEEDS TO BE PASSED ALONG TO AN APPROPRIATE TEAM MEMBER, SUCH AS THE CONSULTING PSYCHIATRIST OR THE PATIENT'S PHYSICIAN.

7) PHYSICAL CONTACT - SOME PEOPLE LIKE TO TOUCH AND BE TOUCHED. OTHERS DON'T. IT IS HELPFUL IF YOU CAN BE FLEXIBLE WITH THIS ISSUE YOURSELF, SO THAT YOU CAN CUE IN ON THE NEEDS OF THOSE YOU ARE SERVING. IN MOST INSTANCES, PATIENTS WELCOME HAND HOLDING AND OTHER APPROPRIATE PHYSICAL GESTURES AS MEANS OF COMMUNICATING, CARING AND 'CONNECTION' WITHOUT NECESSITY FOR TIRING CONVERSATION. FAMILY MEMBERS, TOO, OFTEN RESPOND TO A HAND ON THE ARM OR ACROSS THE SHOULDERS AS A GESTURE OF "I'M HERE. I CARE." IT GOES WITHOUT SAYING THAT THIS DIMENSION OF THE RELATIONSHIP EVOLVES NATURALLY WITH THE PASSAGE OF TIME AND THE INTENSITY OF EVENTS. BE OPEN. DO WHAT FEELS RIGHT. AGAIN, YOUR COMFORT OR DISCOMFORT WILL COMMUNICATE ITSELF CLEARLY, SO IT IS IMPORTANT TO BE YOURSELF.

8) MEET THEM WHERE THEY ARE - OVER AND OVER AGAIN IN YOUR TRAINING, THE CONCEPT OF TUNING IN TO THE FAMILY AND MEETING THEM IN TERMS OF THEIR OWN VALUES AND LIFE PATTERNS WAS STRESSED. REGARDLESS OF HOW MUCH YOU MAY DISAGREE WITH A FAMILY'S WAY OF DEALING WITH THEIR SITUATION, IT IS NEVER APPROPRIATE TO GIVE UNSOLICITED ADVICE. PATTERNS OF INTERACTION BETWEEN FAMILY MEMBERS, NO MATTER HOW COUNTERPRODUCTIVE THEY MAY SEEM TO YOU, HAVE BEEN FORMED OVER YEARS OF ASSOCIATION, AND ARE ROOTED IN A HISTORY OF WHICH YOU ARE NOT A PART. YOUR RESPONSIBILITY IS TO WORK AS HELPFULLY AND HARMONIOUSLY AS POSSIBLE WITHIN THE GIVEN STRUCTURE, NOT TO TRY AND CHANGE IT.

9) INITIATIVE - AT THE OUTSET OF A RELATIONSHIP THE FAMILY WILL USUALLY LOOK TO THE VOLUNTEER TO SET THAT PATTERN OF INTERACTION. REGULAR PHONE CALLS AND BRIEF VISITS TO SEE HOW THINGS ARE GOING ARE USUALLY APPRECIATED AND SERVE TO BREAK THE ICE. DON'T ASSUME THAT SOMEONE DOESN'T NEED TO TALK TO YOU JUST BECAUSE THEY HAVEN'T CALLED YOU. ON THE OTHER HAND, BE SENSITIVE TO THE POSSIBILITY THAT YOU MAY NOT BE NEEDED, AND NEVER PROLONG A CONVERSATION IN WHICH YOU ARE DOING MOST OF THE TALKING.

10) "LITTLE THINGS MEAN A LOT" -

- YOUR PERSONAL GROOMING AND MANNER OF DRESS CAN AFFECT A PATIENT'S MOOD. COLOR AND ATTRACTIVENESS CAN HELP LIFT THE SPIRIT.
- PERFUME OR AFTER-SHAVE CAN BE UNPLEASANT TO PEOPLE ON MEDICATION.
- A POSITIVE ATTITUDE AND PLEASENT EXPRESSION MEAN A LOT. THIS DOES NOT MEAN PHONY CHEERFULNESS OR OVERLY-BRIGHT CHATTINESS, BUT MERELY A CLEAR MESSAGE OF CARING AND ATTENTION.
- CARDS AND FLOWERS BRIGHTEN A ROOM AND REMIND THE PATIENT THAT PEOPLE CARE EVEN WHEN THEY CANNOT BE PRESENT.
- SOMETIMES NOT TALKING, BUT SITTING WITH A PATIENT AND LETTING HIM KNOW YOU CARE BY BEING THERE, IS THE GREATEST GIFT OF ALL.

7/81/KS

NAME: George M Fenner DATE: 2-2-83

ADDRESS: Cogswell Bldg

PHONE: 449-2037

REPRESENTING WHOM? Dept. of Health + Env Sci

APPEARING ON WHICH PROPOSAL: SB 208

DO YOU: SUPPORT? ____ AMEND? ✓ OPPOSE? ____

COMMENTS:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

[illegible] 7

Senate Bill No. 208
(Hospice Licensing Bill)

My name is George M. Fenner. I am Administrator of the Division of Health Services and Medical Facilities and represent the Department of Health and Environmental Sciences. I speak as a proponent of this bill with amendment.

The Department strongly recommends that New Section, Number 3 starting on line 25, page 9, and ending on line 4, page 10, be deleted from this bill. This section deals with licensure based on approval of the Hospice by Joint Commission on Accreditation of Hospitals.

Licensure is a state responsibility. J.C.A.H. has no regulatory authority by virtue of their organization. There is no provision for consultation to the providers they serve as well as no provision for follow-up visits to verify correction of deficiencies to meet compliance with their standards.

A basic J.C.A.H. operational tenet is that providers of health care should voluntarily assess the quality of the care they render. Since participation in the program is voluntary, the approach is necessarily one of peer review. While such an operational mode may be beneficial for educational and consultative programs, it does not lend itself to evaluation, monitoring and adverse action. There is doubt that J.C.A.H. scrutiny can be purely objective when modified by the need for program participants to generate funds to meet operational costs.

No such modifying circumstance exists relative to state licensure. All service providers must comply with existing state requirements in order to operate. If non-compliance is determined, the State Agency has the option of revoking the license or imposing civil penalty.

In addition, J.C.A.H. will not release its reports to the public and does not maintain an office in Montana so that it can be responsive to citizens' complaints, questions or concerns.

The Department urges you to pass this bill with the deletion of New Section 3.

NAME: Jody Gochanour DATE: 2-2-83

ADDRESS: 113 Warren, Anaconda

PHONE: 563-2978

REPRESENTING WHOM? Anaconda Piller Hospice

APPEARING ON WHICH PROPOSAL: SB #208

DO YOU: SUPPORT? X AMEND? ______ OPPOSE? ______

COMMENTS:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Exhibit 5

FOR THE LICENSURE OF HOSPICE S. B. #208 February 2, 1983

My name is Lindy Gochanour, and I am a Hospice volunteer from Anaconda.

To become a volunteer, I attended a 24 hour volunteer orientation program, filled out an application, and was then interviewed by a volunteer coordinator.

Then, in February of 1982, I made a big investment in life. This is when I officially became a Hospice Volunteer Caregiver. This investment has been one of the most rewarding experiences of my life. I have learned a lot about caring, giving, feelings, living, dying, and much more.

A volunteer has to be prepared to give a lot of himself, because when you come away from the experience, you are a much better person. You will never be the same again. You will also realize what is important in life, and what your priorities are.

When you first meet a Hospice patient, ask yourself, "How would I want to be treated if it were me instead of him or her?"

Put yourself in their place, then you will know what they want to have done and how they want to be treated.

The patient isn't any different than you are; it's just that their choices about life have been taken away.

As a volunteer, you go to the home of a person with a terminal illness, usually cancer, and help them whenever help is needed. This can be in the form of companionship, support for the rest of the family, listening, talking, comforting, caring and giving moral support for the patient; light housekeeping, cooking, bathing the patient, and just doing things they would really like to have done. The most important aspect of the volunteer is just being there as a friend.

Some people prefer to stay in their own home until the end, but sometimes when pain-control gets too out of hand, it is necessary to go to the hospital. A Volunteer Caregiver may be asked to sit with the person at the hospital; to give other family members a break. To the dying person, just your presence can be an assurance. Just holding their hand and saying, "I care," when otherwise it would be very costly to hire a "special" nurse to sit with them. A volunteer can relieve a lot of stress on the person's family and save them a lot of expense.

When you are a volunteer, you are not alone; you can always call the Hospice Nurse, and she will be there within 5 - 10 minutes. There is a nurse on call 24 hours a day, 7 days a week.

You are not tied down as a volunteer, because the responsibility is lovingly shared by other volunteers who divide the times when our help is needed. You can go there at your own convenience. You can pick times when you want to get involved.

We, as Volunteers, have a support group, where we can go to meetings and discuss our Caregiving. The members on this team are the physician, Hospice Nurse coordinator, Hospice Volunteer Coordinator, other nurses involved, nutritionist, minister, and the volunteers.

We are also provided with continuing education about different aspects of Hospice.

Our purpose in Hospice is to provide care that will enhance the quality of the remaining life for those who are facing a terminal illness. Hospice care can make this difficult time in a person's life - maybe not better - but easier. We can't take away the emotional trauma for them or the family, but we can help them live through it.

I believe that a Hospice licensure would be very helpful because it would insure Volunteer Professional support, because they can't manage without the back-up. It would insure standards of training, and it would allow clients to stay at home, in familiar surroundings, and would keep medical costs down.

Thank you.

Lindy Gochanour

Lindy Gochanour

NAME: James Milo Manning DATE: Feb 2, 1983

ADDRESS: 518 Hickory Anaconda MT

PHONE: 563-3091

REPRESENTING WHOM? Anaconda Pintler Hospice

APPEARING ON WHICH PROPOSAL: SB 208

DO YOU: SUPPORT? ✓ AMEND? OPPOSE?

COMMENTS:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Exhibit 6 FEB 2, 1983

Ladies & Gentlemen of the Public Health Committee:

My name is James Milo Manning. I live in Anaconda, MT. I would like to offer testimony for SB-208 on the Hospice organization, from the point of view of a family involved.

After a cancer operation and a year of subsequent chemo-therapy treatments, my mother was told in Feb. of 1982 that the treatment was of no further use and that she had a few months to live. All that could be done at that time was medication to contain the pain and to keep her as comfortable as possible. Since the rest of my sisters and brother lived out of town and out of state, the responsibility of care fell on my father who was 70 and my wife and myself. It was about this time that we heard of the Hospice organization.

After attending some hospice meetings and talking to them,we arranged to have Hospice volunteers come to the house to assist in my mother's care.

They were able to prepare meals, assist in housecleaning and to give my father an occasional break. As the weeks passed and my mother became weaker and less mobile, the volunteers provided assistance in moving her in and out of bed, assisting with the oxygen unit and general care.

Another aspect was happening as these volunteer ladies continued to be there, a close relationship formed between them and my mother. They provided the companionship she needed - someone she was able to confide in and express her fears and concerns of her family and of death...things she might not have felt comfortable in telling her family. They were also able to share the outside world with her so she didn't feel so confined.

Hospice nurses and Home Health Care nurses were used to take blood tests, take blood pressures for both my mother and father and were on call in case the pain broke through the normal medication and additional medication was needed.

From time to time my mother also developed blood clots in her legs and she needed to have hot compresses applied. Hospice volunteers were able to be there to help in that treatment.

In the last month of her life, September of 1982, the pain became too intense for home treatment and she was admitted to the hospital. Although her body was wracked with pain, my mother's mind remained alert. The family felt she needed someone near her on a

2/2/83

24 hour basis, someone she could talk to - to help summon a nurse if needed - someone just to help her remain in touch with reality, as she drifted in and out of sleep from intense medication.

Once again the Hospice volunteers came through to help the family provide 24 hour companionship...something that the hospital staff couldn't do nor would be expected to do. Someone was there to call them if something came up but they could concentrate on their other duties and other patientss

In summary, our family has learned that the Hospice organization is a most worthwhile and needed organization...both to the patients and their families in preparing and accepting death. As the funds to enable the organization to operate come from donations, memorials, and grants from private companies, I feel that SB-208 is needed to give the Hospice organization the needed recognition and legitimacy to attract funding. Any organization needs some supervision and SB-208 will provide that supervision also.

Thank you for your time.

James M. M

- Co 4 [illegible] /

JANUARY 14, 1983

MR. THOMAS HOYER
CHIEF OF INSTITUTIONAL SERVICES
OFFICE OF COVERAGE POLICY
ROOM 409, EAST HIGHRISE
6325 SECURITY BOULEVARD
HEALTH CARE FINANCING ADMINISTRATION
BALTIMORE, MARYLAND 21207

RE: SECTION 1811 OF THE SOCIAL SECURITY ACT-MEDICARE REIMBURSEMENT FOR HOSPICE CARE.

DEAR MR. HOYER:

MONTANA IS A STATE WITH LARGE GEOGRAPHIC SPACES AND FEW PEOPLE. THE HEALTH CARE INDUSTRY IN MONTANA IS FACED WITH SHORTAGES OF PERSONNEL, LIMITED FINANCIAL RESOURCES, AND FACILITIES WHICH SERVE SMALL POPULATIONS. WHEN THE HOSPICE MOVEMENT WAS STARTED IN MONTANA THE COALITION MODEL OF HOSPICE CARE WAS ADOPTED STATE WIDE. THE GOAL WAS TO INTEGRATE AND COORDINATE SERVICES PROVIDED BY A VARIETY OF AGENCIES IN ORDER TO MEET THE NEEDS OF THE DYING PATIENT WITHOUT DUPLICATING SERVICES.

THE MONTANA ASSOCIATION OF HOME HEALTH AGENCIES HAS ASSISTED WITH AND SUPPORTED THE EFFORTS OF THE HOSPICE MOVEMENT. UNLESS THE REGULATIONS INTERPRETING THE HOSPICE LEGISLATION ARE WRITTEN IN BROAD TERMS THE HOSPICE PROGRAMS IN MONTANA WILL NOT BE ABLE TO PROVIDE REIMBURSABLE SERVICES TO MEDICARE RECIPIENTS. COMMUNITY BASED HOSPICE PROGRAMS IN MONTANA CURRENTLY DO NOT PROVIDE DIRECT SKILLED NURSING CARE AND OTHER RELATED HOME HEALTH SERVICES. HOSPICE PROGRAMS WILL BE FACED WITH THE DILEMMA OF PROVIDING THE MAJORITY OF SERVICES DIRECTLY THUS DUPLICATING AND INCREASING COST OF HOSPICE AND OTHER RELATED HEALTH CARE SERVICES.

OUR SPECIFIC RECOMMENDATIONS FOR THE REGULATIONS REGARDING HOSPICE LEGISLATION INCLUDE:

> "HOSPICE CARE; HOSPICE PROGRAM" (2) A ( ) (I)
> ALLOW FOR THE AGENCY OR ORGANIZATION TO CONTRACT
> FOR NURSING CARE.

"HOSPICE CARE; HOSPICE PROGRAM" (2) B ( )
ALLOW FOR THE INTERDISCIPLINARY GROUP OF PERSONNEL IN COALITION MODEL HOSPICES TO HAVE MEMBERS WHICH ARE INTERDISCIPLINARY AND FROM A VARIETY OF PARTICIPATING AGENCIES TO BE THE GROUP WHICH " PROVIDES (OR SUPERVISES THE PROVISION OF) CARE AND SERVICES DESCRIBED IN PARAGRAPH (1)

THANK YOU FOR CONSIDERING OUR REQUEST IN THE DEVELOPMENT OF HOSPICE REIMBURSEMENT REGULATIONS.

SINCERELY YOURS:

JANICE TREML
PRESIDENT

CC: THE NATIONAL ASSOCIATON FOR HOME CARE
MONTANA SENATOR MELCHER
MONTANA SENATOR BAUCUS
MONTANA CONGRESSMAN MARLENEE
MONTANA CONGRESSMAN WILLIAMS

NAME: J. W. Greene DATE: 2/2/83

ADDRESS: Star Route East Anaconda MT. 59711

PHONE: 563-7121 — Home 797-3320

REPRESENTING WHOM? Anaconda Pintler Hospice

APPEARING ON WHICH PROPOSAL: S.B. 208

DO YOU: SUPPORT? ✓ AMEND? OPPOSE?

COMMENTS:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Exhibit 8

TESTIMONY OF J. W. GREENE,
EXECUTIVE VICE PRESIDENT,
ANACONDA PINTLER HOSPICE,
SPEAKING IN FAVOR OF S.B. 208

The Hospice movement seeks to provide unlimited caring for patients and their families as the patient passes through the last journey of life. The Hospice movement recognizes dying as a natural process and seeks to increase the quality of the time remaining for the patient. Hospice provides support to the family through its services and aids the family in caring for the ill member.

S.B. 208 seeks to define a Hospice for licensing purposes.

I believe a real need for licensing exists, in view of the new Federal laws which will allow Medicare payments for services rendered by Hospice organizations.

A means must be found to insure that all Hospice organizations state-wide provide quality care for patients and the most effective means to do this is through state-wide licensing and adopting standards for accreditation.

Broadly defined, the Federal Law dictates that a Hospice can either be a public or private group; must provide 24 hour care, bereavement care, uses the interdisciplinary team approach, provides or supervises Hospice services and is licensed according to State law.

That final item in that last sentence "and licensed according to State Law" mandates that Montana Hospices must be licensed if they are to be eligible for Medicare payment.

Therefore, I urge this Committee to support S.B. 208.

NAME: KEVIN McNELIS DATE: 2-2-83

ADDRESS: BOX 60 Rt #1

PHONE: 563-8491 office

REPRESENTING WHOM? ANACONDA PINTLAR HOSPICE

APPEARING ON WHICH PROPOSAL: SB 208

DO YOU: SUPPORT? X AMEND? ____ OPPOSE? ____

COMMENTS: I am in favor of SB 208 because I feel the Hospice Organizatio plays a very important part in the city of Anaconda in dealing with the concerns and problems that face all of us in death. I support any and all legislation that will benefit the Hospice program.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Exhibit 9

SENATE BILL NO. 208

Mr. Chairman:

I move to amend Senate Bill No. 208 on pages 9 and 10 by deleting line 25 on page 9 and lines 1 through 4 on page 10, and substituting in lieu thereof the following:

> "NEW SECTION. Section 3. Exemption from licensing. No licensed hospital shall be required to obtain additional licensing to perform hospice services."

SENATOR HAROLD L. DOVER

SENATE BILL 209

AN ACT TO PROVIDE CRITERIA FOR ADMISSIONS TO THE MONTANA CENTER FOR THE AGED; REVISING THE TRANSFER AND DISCHARGE PROCEDURE; AMENDING SECTIONS 53-21-411 THROUGH 53-21-413, MCA

Senate Bill 209 has been introduced to clarify the mission of the Montana Center for the Aged in Lewistown and to establish basic admission procedures.

The statutes currently define the Center as a mental health facility. This obligates the center to meet the same treatment and transitional goals as Warm Springs State Hospital.

SB 209 clarifies the role of the center in the overall health service delivery system. It states - page 1, lines 14-18, "The primary function of the center is the care and treatment of persons 55 years of age or older. Priority must be given to patients referred from Warm Springs state hospital or Galen state hospital."

The center provides long term care for individuals, as stated on page 2, lines 17-21, "...persons unable to maintain themselves in their homes or communities due to mile psychiatric impairments associated with the aging process but who do not require the intensity of treatment available at Warm Springs or Galen state hospital."
For the vast majority of these people, the psychiatric disability is of a chronic nature, often accompanied by physical deteriation that is associated with old age. The

function of the center is to provide a safe and human environment which recognizes human dignity as these elderly people adapt to long term care at the center. The center is not a transitional mental health facility.

SB 209 would identify the centers function as one for elderly with mild psychiatric impairment associated with the aging process - make clear to the courts and other mental health facilities, the general public and legislators as to - the centers responsibilities and capabilities, and sets up guidelines for development of staffing programs and administrative staff. This change is consistent with the Department of Institutions goal of clarifying the specific mission of each state institution. As the mission of the Center for the Aged has changed to fit within the overall continuum of services, it is important that such change receive legislative sanction.

STATEMENT OF INTENT

SB 209: The Department of Institutions is requesting legislation that would clarify the role of the Montana Center for the Aged in Lewistown and provide for an admission procedure.

The Department of Institutions is requesting legislative authority under rule making provisions that it be given clear rule making authority for the admission criteria of persons who are unable to maintain themselves in the community due to the aging process.

Criteria that would be considered under the rule making authority include:

(a) consideration of persons's age,
(b) consideration of persons's mental and physical status, specifically as it relates to mild psychiatric impairments, senility, and other organic symptoms,
(c) consideration of ability of Center for the Aged to meet the person's needs,
(d) consideration of person's sex as relates to availability of appropriate living space.
(e) consideration of person's ability to ambulate without special devices or physical assistance,
(f) voluntary admissions.

Specifically this rule making authority should give the Department the ability to adopt rules indicating the type of medical and mental illnesses involved, the evaluation and diagnosis process of mental health professionals and physicians.

Standards for determining the programs that will be provided for residents at the Center for the Aged.

Specific criteria relative to transfers necessary to other facilities and, discharge criteria, if any, from the institution, if needed. It is the intention that these rules make it very clear that acute psychiatric problems are not to be used for admission to the Center for the Aged.

-END-

NAME: Murphy, Clifford H. DATE: 7/2/83

ADDRESS: 1301 Rimrock Rd., Billings, MT. 59102

PHONE: 252-1685

REPRESENTING WHOM? Board, Mental Health Assoc. of MT.

APPEARING ON WHICH PROPOSAL: SB209

DO YOU: SUPPORT? ✓ AMEND? ______ OPPOSE? ______

COMMENTS: ______

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

NAME: Shirley Thennis DATE: 2/2/83

ADDRESS:

PHONE: 227-6348

REPRESENTING WHOM? Montana Nurses Assn.

APPEARING ON WHICH PROPOSAL: 209

DO YOU: SUPPORT? ______ AMEND? ______ OPPOSE? ✓

COMMENTS:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Exhibit 10

Montana Nurses' Association

2001 ELEVENTH AVENUE (406) 442-6710

P.O. BOX 5718 • HELENA, MONTANA 59604

TESTIMONY ON S.B. #209

I find it difficult to believe that the omission of family notification can serve any purpose and I for one would be furious if a family member of mine were transfered without my knowledge. We are not talking about cattle. We are talking about elderly people. People who are unfortunate enough to have impaired mental abilities, but people just the same. Certainly, these people are far more susceptible to confusion and disorientation, and need time to adjust, with family help to any move.

Family notification should be required anytime a patient is transfered from one state facility to another - whatever the facilities may be.

Proposed Amendments to Senate Bill No. 214

1. Title, lines 6 and 7.
   Following: "DEPARTMENT OF INSTITUTIONS"
   Strike: "AND THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES"

2. Title, line 8.
   Strike: DEPARTMENTS
   Insert: DEPARTMENT

3. Page 3, line 1.
   Strike: line 1 on page 3 in its entirety.

4. Page 4, line 15 through 16.
   Following: "The department"
   Strike: "and the department of social and rehabilitation services"

5. Page 4, lines 18 and 19.
   Following: "The department"
   Strike: "and the department of social and rehabilitation services."

SB-182

PROPOSED REVISIONS TO MONTANA SOLID WASTE DISPOSAL RULES

During the March 24, 1982, meeting of the Legislative Administrative Codes Committee in Helena, considerable testimony was given pro and con for revision of certain sections of the Montana Solid Waste Disposal Rules. The Chairman of the Committee requested that individuals involved in complying with and enforcing the existing rules, develop a proposed revision to the rules in question. Specifically, revisions to Section 16.14.521, Subsections 2(a) and 2(c) were requested.

Below, please find proposed revisions to the two rules in question for your review and comment.

Section 16.14.521, Subsection 2(a) currently reads:

> "All Class II sites using landfilling methods shall compact and cover solid waste with a layer of at least six (6) inches of approved earth cover material at the end of each operating day and at least two (2) feet of approved earth cover material within one week after final deposit of solid waste at any portion of the site. These steps must be taken unless the Department is satisfied that the licensee has shown good cause for not covering."

It is proposed that Section 16.14.521, Subsection 2(a) be revised to read as follows:

> "All Class II sites serving rural, unincorporated areas, or municipal corporations classified as "towns" pursuant to Section 7-1-4111 M.C.A., that utilize landfilling methods for solid waste disposal, shall provide periodic application of cover material once each week in such a manner as to reduce the risk of fire and to impede vector's access to the waste. Such landfills may remain open seven (7) days each week. Should periodic inspections of the site conducted by the Department and/or local health authority document consistant and on-going problems that could result in potential public health or safety hazards, the Department may require the landfill to cover more frequently than once each week in order to rectify on-going problems. Class II sites serving Third Class Municipalities, as defined pursuant to Section 7-1-4111 M.C.A., that utilize landfilling methods for solid waste disposal, shall provide periodic applica- of cover material at a frequency to be determined jointly by the Department, local health authority, and local governing body. Class II sites serving First and Second Class Municipalities, as defined pursuant to Section 7-1-4111 M.C.A., that utilize landfilling methods for solid waste disposal, shall provide application of cover material at the end of each operation day. All Class II landfill sites shall provide a final cover of at least two (2) feet of approved earth cover after the final deposit of solid waste has been made."

Section 16.14.521, Subsection 2(c) currently reads:

"Sites shall be fenced to prevent unauthorized access and shall be supervised when open."

It is proposed that Section 16.14.521, Subsection 2(c) be revised to read as follows:

"All Class II landfill sites serving rural, unincorporated areas, or municipal corporations classified as "towns" pursuant to Section 7-1-4111 M.C.A., shall provide litter control fences around the site and adequate informational and directional signs to inform the general public as to proper dumping locations and procedures. All Class II landfill sites serving Third Class Municipalities, as defined pursuant to Section 7-1-4111, M.C.A., shall provide litter control fences around the site and adequate access control and supervision, which shall be determined jointly by the Department, local health authority, and the local governing body. Class II landfill sites serving First and Second Class Municipalities as defined pursuant to Section 7-1-4111, M.C.A., shall be fenced to prevent unauthorized access and shall be supervised when open."

WASTE MANAGEMENT FACILITIES CONTRACTING WITH PRIVATE SECTOR

AREA	CLASSIFICATION	ACTUAL POPULATION SERVED
Beaverhead County		
Dillon	3rd	6,587
Big Horn County		
County Container Sys.	Rural	7,800
CX Ranch	NA	Company
Decker East	NA	Company
Decker West	NA	Company
Spring Creek	NA	Company
Spring Creek Townsite	NA	Company
Blaine County		
Chinook	3rd	3,170
Harlem	3rd	1,961
Turner	Rural	300
Carbon County		
Bridger	Rural	1,000
Red Lodge	3rd	3,706
Carter County		
Ekalaka	Rural	1,100
Cascade County		
City Transfer	Rural	8,000
Chouteau County		
Fort Benton	3rd	2,865
Custer County		
Miles City	2nd	11,830
Dawson County		
Glendive	2nd	10,305
Deer Lodge County		
Anaconda	1st	12,507
Fergus County		
Mr. "M" Disposal	2nd	6,000 approximate
ACT Disposal	2nd	6,000 approximate
Gallatin County		
Logan	Rural	20,000
West Yellowstone	Rural	2,000 approximate
Jefferson County		
Boulder	Rural	4,510
Whitehall	Rural	2,530

AREA	CLASSIFICATION	ACTUAL POPULATION SERVED
Lewis & Clark County		
Augusta	Rural	847
Lincoln	Rural	2,233
Lincoln County		
County Container System	Rural	UNK
McCone County		
Brockway	Rural	400
Circle	Rural	1,771
Meagher County		
White Sulphur Springs	3rd	1,769
Mineral County		
Felstet	Rural	3,674
Missoula County		
Browning-Ferris	1st	75,432
Browning-Ferris Class III	NA	NA
Park County		
Clyde Park	Rural	282
Pondera County		
Conrad	3rd	4,522
Dupuyer	Rural	600
Powder River County		
Broadus	Rural	1,323
Powell County		
Deer Lodge	3rd	5,454
Ravalli County		
Darby	Rural	1,721
Sula	Rural	200
Victor	Rural	20,000
Richland County		
County Container System	Rural	6,500
Rosebud County		
Colstrip	Rural	9,965
Sanders County		
Hot Springs	Rural	1,772
Noxon	Rural	200

AREA	CLASSIFICATION	ACTUAL POPULATION SERVED
Sanders County (Cont.)		
Plains	Rural	2,553
Thompson Falls	Rural	3,800
Trout Creek	Rural	150
Sheridan County		
Plentywood	3rd	3,540
Silver Bow County		
Butte	1st	37,750
Teton County		
Choteau	3rd	3,475
Toole County		
Kevin	Rural	250
Valley County		
Glasgow	3rd	6,634
Hinsdale	Rural	390
Nashua	Rural	496
Yellowstone County		
Broadview Container	Rural	125

STANDING COMMITTEE REPORT

FEBRUARY 3 19 83

MR. PRESIDENT

We, your committee on PUBLIC HEALTH

having had under consideration Statement of Intent SENATE Bill No. 209

Respectfully report as follows: That Statement of Intent SENATE Bill No. 209

be adopted.

STATEMENT OF INTENT RE: SB 209

The Department of Institutions is requesting legislation that would clarify the role of the Montana Center for the Aged in Lewistown and provide for an admission procedure.

The Department of Institutions is requesting legislative authority under rule making provisions that it be given clear rule making authority for the admission criteria of persons who are unable to maintain themselves in the community due to the aging process.

Criteria that would be considered under the rule making authority include:

(a) consideration of person's age,
(b) consideration of person's mental and physical status, specifically as it relates to mild psychiatric impairments, senility, and other organic symptoms,

~~DO PASS~~

(cont.)

Chairman.

STATE PUB. CO.
Helena, Mont.

STANDING COMMITTEE REPORT

FEBRUARY 3 1983

MR. PRESIDENT:

We, your committee on PUBLIC HEALTH, WELFARE AND SAFETY

having had under consideration SENATE Bill No. 209

Respectfully report as follows: That SENATE Bill No. 209,
introduced copy, be amended as follows:

1. Page 2
Following: line 6
Insert: "Unless a medical or psychiatric emergency exists, 15 days prior to the transfer the department shall notify the patient's parent, guardian, or spouse or, if none is known, his nearest relative or friends. In the case of an emergency transfer, the department shall send notice within 72 hours after the time of transfer."

And as so amended,
DO PASS

Statement of Intent, Attached

SENATOR TOM HAGER Chairman.

STATE PUB. CO.
Helena, Mont.

FEBRUARY 3 19 83

(c) consideration of ability of Center for the Aged to meet with person's needs,
(d) consideration of person's sex as relates to availability of appropriate living space,
(e) consideration of person's ability to ambulate without special devices or physical assistance,
(f) voluntary admissions.

Specifically this rule making authority should give the Department the ability to adopt rules indicating the type of medical and mental illnesses involved, the evaluation and diagnosis process of mental health professionals and physicians.

Standards for determining the programs that will be provided for residents at the Center for the Aged.

Specific criteria relative to transfers necessary to other facilities and, discharge criteria, if any, from the institution, if needed. It is the intention that these rules make it very clear that acute psychiatric problems are not to be used for admission to the Center for the Aged.

SENATOR TOM HAGER Chairman.

STATE PUB. CO.
Helena, Mont.