



RAMONA VNA AND HOSPICE

"Keeping the Heart in Hospice"

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July 11, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3844-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: File Code CMS-3844-P

Dear Sir or Madam:

Enclosed herewith, please find our comments for submission and consideration relative to the proposed rule changes to 42 CFR Part 418, Medicare and Medicaid Programs, Hospice Conditions of Participation; Proposed Rule.

Respectfully Submitted,

Karen L. Estes, RN, BSN, CHPN

Karen L. Estes, RN, BSN, CHPN
Hospice Program Director

MEMBER **VNA**A - Visiting Nurse Associations
of America™

890 W. Stetson Avenue, Suite A · Hemet, California 92543
Phone: (909) 658-9288 · Fax: (909) 765-6229

**2005 Proposed Medicare Conditions of Participation
for Hospice Programs Request for Comments**

Ramona VNA & Hospice
890 W Stetson Ave, Suite A
Hemet, CA 92543

2005 CMS Proposed CoP's	Request for Comments
<p>418.3 Definitions Drug Restraint (pg 3)</p>	<p>This definition is inappropriate for hospice care, as many drugs that would fit this definition are widely used and considered the industry standard in treating restlessness, terminal restlessness, anxiety, etc. Often medications fitting this definition are in fact used to decrease suffering for the patient, up to and including providing terminal sedation if all other measures have failed to relieve suffering. Effective treatment of terminal agitation and poorly controlled pain requires medications at doses currently considered to be "drug restraints" by various regulatory bodies. For example, skilled nursing facilities prohibit or strongly discourage using Ativan (lorazepam), at doses greater than 2 mg per day, regardless of the clinical situation. The American Academy of Hospice and Palliative Medicine (AAHPM) recommends using Ativan (lorazepam) at doses of 1-2 mg per hour in the treatment of moderate to severe agitated delirium.¹</p> <p>The terminology "standard treatment" is particularly problematic. Standards created by state regulatory agencies pertaining to nursing home and skilled facility residents in California currently make no exception for patients under hospice care. Because of this, many patients are currently being denied access to medications that would be considered "standard treatment" by the AAHPM. It is often necessary to use narcotics and psychotropic medications in hospice patients at doses which are likely to "control behavior... (and)...restrict the patient's freedom of movement". These outcomes are unintended consequences of using the necessary agents to relieve pain and manage terminal agitation.</p> <p>¹ Pocket Guide to Hospice/Palliative Medicine, Table 57, page 106, ISBN1-889296-35-X</p>
<p>418.3 Definitions Licensed professional (pg 4)</p>	<p>In some states, Social Workers are not licensed, but they are included in this definition. Social Worker should be defined by itself.</p>
<p>418.3 Definitions Physical Restraint (pg 5)</p>	<p>This definition is inappropriate for hospice care, as many DME pieces that are commonly used to assist the patient would be inappropriate under this definition. It is common practice to use bedrails (full and half), over bed tables (which must be placed over or next to the patient for access), Geri-Chair's, Merry Walker's, w/c lap belts, Lap Buddy's to assist patients in being safe, and mobile as long as possible. Sometimes families request Posey vests to prevent the patient (who is confused, weak, and/or unrealistic about their ability to ambulate) from harming themselves.</p>
<p>418.3 Definitions Terminally Ill (pg 6)</p>	<p>Many patients reject hospice care because of the short prognosis language and what that represents to them. Many physicians hesitate to refer to hospice thinking they will suffer consequences if the patient does not die in the 6 months. Consider the following:</p>

- ✓ Prognostic error is widespread
- ✓ Only around 20% of estimates are accurate^{2,3}
- ✓ Physicians are much more likely to overestimate than underestimate life expectancy⁴

Irene J Higginson and Massimo Costantini⁵ conducted a prospective cohort study regarding the accuracy of prognosis by skilled palliative care teams in terminally ill patients. One would expect that teams specializing in palliative care would be more likely to provide an accurate prognosis than physicians at large. One finding of the study was that offering a prognosis range (i.e. 6 to 12 months) was much more accurate than a specific prognosis. The study concluded that: ***“Offering a prognosis range has higher levels of accuracy (about double) than traditional estimates, but is still very often inaccurate, except very close to death. Where possible clinicians should discuss scenarios with patients, rather than giving a prognosis range.”***

Because the Medicare Hospice benefit requires a patient be “terminally ill” to qualify, it seems imperative that a more accurate definition than that proposed be used. Both of these things combine to result in patients accepting and entering into hospice care much too late to truly receive the benefits of hospice in its finest form. Removing language that causes the most concern to patients, families and physicians would improve access to this entitled benefit.

Given the above evidence based findings regarding prognosis, and the tendency of physicians to overestimate life expectancy, a more suitable definition of “*Terminally Ill*” is suggested below:

Terminally Ill means that a patient has a medical prognosis such that it is more likely than not that the patients life expectancy is 6 to 12 months (or less) if the illness runs its normal course.

² Mackillop WJ, Quirt CF: **Measuring the accuracy of prognostic judgments in Oncology.**

J Pain Symptom Manage 1997, 50:21-9.

³Christakis NA, Lamont EB: **Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study.**

BMJ 2000, 320:469-73.

⁴ Lamont EB, Christakis NA: **Some elements of prognosis in terminal cancer.**

Oncology (Huntingt) 1999, 13:1165-70.

⁵ Higginson, Irene J and Costantini, Massimo: **Accuracy of prognosis estimates by four palliative care teams: a prospective cohort study.** *BMC Palliative Care* 2002, 1:1.

418.52 Condition of Participation: Patient's Rights
Standard: Notice of Rights (pg 6)
(a) (1)

This standard as written would be nearly impossible for agency's to comply (both verbal and written). In addition to the difficulty in finding an Interpreter for more obscure languages, most languages have words that mean many different things, and there are regional differences (dialects) that would not translate accurately, or appropriately. Even

		hospitals are not held to this standard of providing this information both verbally and written. Family members should also qualify as interpreters in addition to others providing interpretation.
418.52 Condition of Participation: Patient's Rights Standard: Notice of Rights (pg 6) (a) (3)		Patients and families are overwhelmed enough trying to comprehend the information related to philosophy of care, scope and frequency of services, 24 hour availability, levels of care, certification, etc. Many times hospice providers receive calls resulting from confusion in understanding information only moments after staff leaves the home. While very important, trying to clarify drug policies, procedures, tracking, etc. at this time would be ineffective at best. If in fact, providing the information in writing and leaving it with the patient/family would be deemed sufficient by surveyors, this would seem to be the most appropriate way of dispensing this information. Also, there should be some grace period in providing this information, and agree with the suggestion that this correspond to the time frame for the comprehensive assessment.
418.52 Condition of Participation: Patient's Rights Standard: Exercise of rights and respect for property and person (pg 7) (b) (iv)		Suggest the addition of "...including the right to refuse treatment." at the end of the sentence.
418.52 Condition of Participation: Patient's Rights Standard: Exercise of rights and respect for property and person (pg 7) (b) (4) (i) (ii) (iii) and (iv)		Concur with the proposed language from HHA CoP Requirement 484.10 and the deletion of the language under (4) (i), (ii), (iii), and (iv). Our current practice in this area includes providing the patient/family information on admission regarding contacting the Agency with any concerns about their care or our staff providing care. The patient/family is encouraged to call the Team Manager or the Director. The Medicare and State Hotline numbers are provided upon admission, and if there is not satisfactory resolution after discussion the situation with a manager/director, then the patient and family are reminded of their right to call one or both Hotlines. All complaints are investigated fully, documented and resolved, if possible, in a timely manner. If employee counseling is required it is accomplished in a timely manner. Follow up is accomplished in meetings, through plans of correction, and, if necessary, changes in Policy and Procedure.
418.52 Condition of Participation: Patient's Rights Standard: Patient liability (pg 8) (e)		Again, the requirement for verbal and written translation is overly burdensome and would be very difficult for hospice to operationalize this standard. Suggestion that this information is provided in writing, or verbally, and that a copy of the information is left with the patient/family for reference, if the translation is available in writing. It is impossible to accurately determine the patient's liability with respect to Room and Board under Medicaid (State) programs at the time of admission. Because State's have many different ways of operationalizing their programs, it requires time to get consent for services, and then investigate coverage and liability. We believe this language is too restrictive and would cause hospices to be out of compliance with this standard through circumstances beyond their control.
418.54 Condition of Participation: Comprehensive Assessment of the Patient. (pg 9)		The statement regarding the hospice's responsibility to perform a comprehensive assessment (later referred to as and "initial" assessment, does not indicate whether this is an "evaluation visit", or the "admission visit". Many

hospices utilize Social Workers, LVN/LPN's, business development, and volunteers to perform these evaluation visits. If that is what this is referring to, it would place an undue burden on hospice providers, especially in light of the nursing shortage and the recommendation for setting time parameters. Hospices can respond much more timely and efficiently if allowed to use other than RN's for these visits. A recommendation was discussed to change "care" to "assessment" in the last sentence. Our disagreement is based upon the fact that a LVN cannot "assess."

If in fact this is referring to an admission visit then our position is as follows. The requirement that the initial visit occur within 24 hours of the physician order seems to overlook the common issue of family preference and availability. Admission to the hospice program requires both a physician certification as well as a patient's consent. Perhaps the language should indicate that the initial assessment requires a physician's certification of eligibility and must be completed within 24 hours of the patient's consent to begin hospice services. The regulation should not impose a time restraint based on the physician's certification that does not allow for the family to elect when to begin their hospice benefit.

The proposed language seems to suggest that the physician, not the patient controls the election of hospice services. What if the physician gives the certification while the patient is in a SNF for treatments covered under Medicare and the patient elects to utilize their skilled care days before initiating hospice? The proposed language seems to mandate the timing of the assessment based on the physician certification as opposed to the patient's election of hospice. Changes in the language are suggested below:

"The hospice registered nurse must complete an initial assessment visit within 24 hours of admission to hospice, after the hospice receives both the physician's certification for hospice care and the election of hospice consent forms completed by the patient or his/her designee. The purpose of the initial assessment is to determine the patient's immediate care and support needs. The patient reserves the right to determine when to initiate hospice services. "

418.54 Condition of Participation: Comprehensive Assessment of the Patient.

(a) Standard: Initial Assessment (pg 9)

Again, the confusion related to the definition of "initial assessment" is very problematic here. Also, Home Health is allowed 48 hours in this area, and hospice should be afforded at least the same. Operationalizing this standard would prove very difficult, even impossible, for some providers. As to the physician's order, depending on the definition, this could be an order for a pre-admit visit/explanation or an order for admission to hospice. This needs to be clarified. We concur with the suggestion to add language which allows for the patient/family to impact the timeframe of the admission. This should not be in the control of the physician. Again, depending on the definition of initial assessment, this standard should not restrict the provision of a pre-admit visit to being performed by the RN. It is impractical. If in fact this standard is not referring to a pre-admit visit, but truly the intake assessment, then the RN is the appropriate person.

		<p>Suggested changes:</p> <p>(i) A doctor of medicine or osteopathy (who is not the patient's attending physician).</p> <p>Patients may select the Hospice Medical Director as their "attending physician" for a number of reasons:</p> <ul style="list-style-type: none"> ✓ The patient has relocated from out of state and has no attending physician. ✓ The patient's attending can not provide house calls, which may be required ✓ The patient's attending elects not to follow patient's receiving hospice care <p>The hospice regulations require the hospice to provide a physician to be available to patients in the event that they do not have an attending physician available. The regulations also support the patient's right to select the hospice physician as their attending physician.</p>
<p>418.54 Condition of Participation: Comprehensive Assessment of the Patient. (b) Standard: Time frame for completion of the comprehensive assessment. (pg 10)</p>		<p>We strongly support NHPCO's recommendation of 7-calendar days for completion. Also, we would not mind to see the imposition of time frames for Social Services and Chaplaincy, as long as the language allows for patient/family preference to supersede the regulatory time frame. As to the involvement of the attending physician, this language is too restrictive. Most Attendings do not desire this much input, but rather rely on the hospice to manage the plan of care with only minimal input from them.</p> <p>This should be 7 days due to logistics of convening an IDT outside of the normal schedule. A time frame of 4 days would not allow adequate time for the social worker and /or chaplain to accomplish an initial assessment. The language that specifically identifies the attending physician seems redundant as the attending physician is already considered a member of the patient's interdisciplinary team.</p> <p>The proposed language should be changed as the requirement to "consult" with the attending is onerous. In many instances, attending physicians refer their patients to hospice to obtain expertise in palliative pain and symptom control (i.e. the Hospice Medical Director is serving as the "Consultant" to the attending physician). In our experience, the attending physician does not want to be "consulted" regarding palliative care, and requests that the palliative interventions be managed by the Hospice Medical Director.</p> <p>The proposed wording is also problematic in that the Hospice has no control over the availability of the attending physician. In many instances the attending physician is simply not available for "consultation".</p> <p><i>"The hospice interdisciplinary group must complete the comprehensive assessment no later than 7 days after the patient elects to <u>begin</u> the hospice benefit. This assessment should be coordinated with the attending physician or his/her designee."</i></p>
<p>418.54 Condition of Participation: Comprehensive Assessment of the Patient. (c) Standard: Content of the comprehensive assessment. (pg 11)</p>		<p>We concur with the addition of language to indicate that this needs assessment is driven by the patient/family. Agree with the suggestion that the language limits coverage and hospice should be responsible for assessing comprehensively, but be charged ONLY with providing</p>

		<p>palliation and management of the terminal illness. Also, there should be clarification in the language about what is appropriate/not appropriate to cover. Many hospices have elected to cover ALL patient meds, related or not. We feel strongly that taking this approach drives patient choice and is in effect solicitation/enticement. Hospices need to be limited to the provision of medications/DME, etc. related solely to the terminal diagnosis and the symptoms related to by the terminal diagnosis. There is also the question of palliative driven medications, versus disease driven medications. The regulation would lead you to the disease driven approach which would eliminate hospices paying for patient's pre-existing pain or other medications.</p>
<p>418.54 Condition of Participation: Comprehensive Assessment of the Patient. (d) Standard: Update of the comprehensive assessment. (pg 11-12)</p>		<p>We strongly agree with recommendation for <i>updating every 2 calendar weeks rather than every 14 days</i>. The 14 days causes many operational issues, especially around weeks with holidays. It would be difficult to argue that a review which took place on day 15 would be any less effective or appropriate than a review on day 14. We would suggest that the reassessment prior to recertification would occur within the two calendar weeks prior to the end of the current certification period.</p>
<p>418.56 Condition of Participation: Interdisciplinary group care planning and coordination of services. (a) Standard: Approach to service delivery (pg 13)</p>		<p>We would be in agreement with leadership of the IDT/care plan being unrestricted to qualified health care professionals. Nursing dominance of the plan of care has long been an issue. As we are regulated to be interdisciplinary, it would seem to be appropriate for oversight to not be restricted.</p>
<p>418.56 Condition of Participation: Interdisciplinary group care planning and coordination of services. (a) (1) (i) Standard: Approach to service delivery (pg 13)</p>		<p>We would agree with removing the language in parenthesis after (a) (1) (i) "(who is not the patient's attending physician)" – many hospices contract with physicians and often they may in fact be the attending physician and hospice medical director.</p>
<p>418.56 Condition of Participation: Interdisciplinary group care planning and coordination of services. (a) (2) Standard: Approach to service delivery (pg 13-14)</p>		<p>It should NOT be the responsibility of the IDT to establish policies governing the day-to-day provision of hospice care and services. This responsibility belongs to the administrative team with oversight by the Board or other governing body.</p>
<p>418.56 Condition of Participation: Interdisciplinary group care planning and coordination of services. (c) Standard: Content of the plan of care. (pg 14)</p>		<p>Agree strongly with the insertion of the language "services for the palliation and/or management of the terminal condition including..." so that it is clear the hospice is not to treat all the patient's problems.</p>
<p>418.56 Condition of Participation: Interdisciplinary group care planning and coordination of services. (c) (2) (pg 14)</p>		<p>Would suggest that scope and frequency for patients in any setting are fluid and ever changing. It is possible to pick a starting point, based upon the patient/family/caregiver input and adjust appropriately as needs change.</p>
<p>418.56 Condition of Participation: Interdisciplinary group care planning and coordination of services. (c) (6) (pg 15)</p>		<p>Based upon the patient's right to self determination of their end of life care, many times there is NOT "agreement" between the parties with regard to the plan of care. We agree with removing the word agreement to allow for these instances.</p>
<p>418.56 Condition of Participation: Interdisciplinary group care planning and coordination of services. (d) Standard: Review of the plan of care (pg 15)</p>		<p>We find this language too restrictive in terms of the involvement of the attending physician. As stated earlier, most Attendings do not want to be involved in the care planning process, only to be kept updated as to what is occurring with the patient. We do have concerns that the</p>

		Medical Director is being elevated above the IDT rather than a very integral part of the IDT. We would be supportive of the suggested re-write.
418.56 Condition of Participation: Interdisciplinary group care planning and coordination of services. (e) Standard: Coordination of services (4) (pg 15)		This sharing of information has proven very frustrating within providers interpretations of the HIPAA guidelines. Many times the patient is a shared patient, but providers interpret very differently what they may or may not share which makes coordination of services difficult at best. We would support the proposed additions.
418.58 Condition of Participation: Quality assessment and performance improvement. (a) (2) Standard: Program Scope. (pg 16)		Suggest consistency of verbiage related to QAPI throughout regulations.
418.58 Condition of Participation: Quality assessment and performance improvement. (b) Standard: Program Data. (pg 16-17)		We simply request that the data collected by reasonable to collect, relevant, and meaningful to hospice care. Many current data set models are irrelevant to hospice and it is a burden to collect meaningless information.
418.58 Condition of Participation: Quality assessment and performance improvement. (c) Standard: Program Activities (pg 17)		Need to define "adverse event" in a way appropriate to hospice care. We define "adverse event" as "An unplanned event which causes significant injury or hastens death as compared to the normal, expected progression of the terminal diagnosis." The definition in the CMS comment would mean that any death would be adverse.
418.58 Condition of Participation: Quality assessment and performance improvement. (e) Standard: Executive responsibilities. (pg 17)		We propose that the Governing Body maintains <i>oversight</i> of the QAPI program in order to identify trends in care and process improvement areas. This is typically accomplished through a QI Sub-committee which reports back to the full governing body. This would seem most appropriate.
418.62 Condition of Participation: Licensed professional services (b) (pg 18)		Agree with the addition of the word "hospice".
418.64 Condition of Participation: Core services (pg 19)		We support contracting services for Continuous Care in order to meet the needs and provide this level of care; however we do recognize that there could be issues of continuity and quality of care when using non-employee providers. It would be the responsibility of the hospice to ensure the continuity and quality and address issues related to this immediately. Our hospice RN's visit daily patients on Continuous Care, and provide oversight through this visit.
418.64 Condition of Participation: Core services (d) Standard counseling services (pg 20)		We, like many hospice providers, extend bereavement care to patients, families, and staff in the nursing home setting. Under this proposed regulation there are many definition areas of concern. <ol style="list-style-type: none"> (1) Burden of widely providing bereavement services to all caregivers. (2) HIPAA concerns related to extending bereavement to residents of a facility. (3) Need for a definition of "available", "counseling" and "identified" in the Bereavement plan of care. (4) Should there be a timeframe for developing the bereavement plan of care? (5) What does CMS propose as they look to improve bereavement services? (6)
418.76 Condition of Participation: Home health aide and homemaker services. (f) Standard: Eligible training organizations (pg 27)		We support the substitution language proposed.

<p>418.76 Condition of Participation: Home health aide and homemaker services. (g) Standard: Home health aide assignments and duties. (1) (pg 28)</p>	<p>Would this definition allow for LVN/LPN's to make assignments for HHA's? We STRONGLY disagree with HHA's administering medication at any time.</p>
<p>418.76 Condition of Participation: Home health aide and homemaker services. (g) (2) (i) (pg 28)</p>	<p>We do not support needing a physician's order to adjust the HHA plan of care, scope or frequency of visits. The team (including the patient/family/caregiver) should be allowed total authority in adjusting the plan of care in order to meet the very fluctuating needs.</p>
<p>418.76 Condition of Participation: Home health aide and homemaker services. (g) (3) (iv) (pg 28)</p>	<p>We do not support HHA's administering medications at any time.</p>
<p>418.76 Condition of Participation: Home health aide and homemaker services. (h) Standard: Supervision of Home Health Aides (pg 29)</p>	<p>"Qualified therapist" needs to be defined. Why is an onsite visit required every 14 days? We believe that a phone assessment also provides the same information and is entirely appropriate. We again would support this being "every two calendar weeks" rather than every 14 days. The requirement for direct observation every 28 days is restrictive and does not relate to short length of stay. Direct supervision is not currently required. If it is to be required, then we would support the language "every month" so as not to be out of compliance if the visit is done on the 29th day. We support the issue of competency testing, which at our agency is done upon hire and then again annually or any time a need is identified and believe that this process eliminates the need for direct supervisory visits.</p>
<p>418.78 Condition of Participation: Volunteers (e) Standard: level of activity (pg 30-31)</p>	<p>Would appreciate guidance/recommendations for volunteer documentation issues. Also, for guidance as to what "counts" toward the 5%. If, for example, a group of volunteers gets together and makes quilts 4 times a year, which are then distributed to patients throughout the year, these hours should count as volunteer hours. The intent is that while the name of the individual(s) may not yet be known, the quilt is made for the express use of a patient/family and therefore all the time was specifically dedicated to patients. This area is very vague and not consistently calculated from hospice to hospice.</p>
<p>418.100 Condition of Participation: Organization and administration of services (e) Standard: Professional management. (pg 32)</p>	<p>We concur with the requirement about "supervision of staff" (as opposed to requiring supervision of services) as per the comments. We disagree STRONGLY with the language "Furnished in a safe and effective manner by personnel having at least the same qualifications as hospice employees..." This language would make contracting or arranging for service by anyone impossible. The people we contract with, nurses in the hospital or SNF are not trained in hospice care. We feel this language is too restrictive.</p>
<p>418.102 Condition of Participation: Medical Director (pg 34)</p>	<p>The COP's already state that the Hospice is responsible to coordinate and manage all aspects of professional care. To reiterate this requirement here is redundant and unnecessary. The proposed language is also problematic because it seems to exclude other members of the IDG from the communication/coordination process.</p> <p>Below are suggested revisions to the wording:</p> <p><i>The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is either employed by, or under contract with, the hospice. When the medical director is not available, a physician designated by the medical director</i></p>

		<p><i>(or the hospice) assumes the same responsibilities and obligations as the medical director.</i></p> <p><i>The medical director and physician designee coordinate with other physicians and health care professionals to ensure that each patient experiences medical care that reflects hospice policy.</i></p> <p><i>(Or)</i> <i>The (IDG, including the) medical director and physician designee, coordinate with other physicians and health care professionals to ensure that each patient experiences medical care that reflects hospice policy.</i></p> <p>With regard to the language concerning when the medical director is unavailable and choosing a physician designee, if that physician is not under contract with the hospice doesn't this present a HIPAA violation (neither an employee nor contract)?</p>
<p>418.102 Condition of Participation: Medical Director (c) Standard: Coordination of medical care. (pg 35)</p>		<p>We believe that it would be impossible for the majority of hospices to find contract medical directors who are willing or able to head the QAPI program. Further, this takes away from the patient care time the medical director has and removes him/her from patients that much farther. The Medical Director certainly should participate in the QAPI program, but need not be set aside as having this primary responsibility. If the duties can be assigned to another staff member, nearly 100% of hospices would choose to do this. We fully support the suggestion to expand this to "or other qualified professional" so that an employee could do this work and oversee the program.</p>
<p>418.104 Condition of Participation: Clinical Records (pg 35-36)</p>		<p>Agree with clarification requested as to "accurate" records.</p>
<p>418.104 Condition of Participation: Clinical Records (b) Standard: Authentication (pg 37)</p>		<p>We question what is required to authenticate the signatures? This standard is too broad and burdensome given the "mobile" nature of hospice work. Home Health Agencies and Nursing Facilities are not held to this standard. We strongly support removing this issue from the standard.</p>
<p>418.104 Condition of Participation: Clinical Records (e) Standard: Discharge or transfer of care (pg 38)</p>		<p>The burden placed by this standard far exceeds the attempt to require communication between providers. The need to copy the entire medical record and provide it to either another facility or primary physician is a waste of resources (staff and paper); impractical and the real question is "who will honestly read that chart?" No one. We strongly support using the discharge summary, whose content could be defined, and any other appropriate documentation needed.</p>
<p>418.106 Condition of Participation: Drugs, controlled drugs and biologicals, medical supplies, and DME. (b) Standard: Controlled drugs in the patient's home (pg 39)</p>		<p>Please see our earlier concern (418.52 (a) (3)) about this information being a required part of the initial assessment. We disagree with the use of the phrase "potential dangers of controlled substances." We would support language detailing side effects, benefits and risks of therapy, and safety issues related to use of controlled substances when place in the home environment.</p>
<p>418.104 Condition of Participation: Clinical Records (c) Standard: Use and maintenance of equipment and supplies. (pg 39)</p>		<p>We strongly support the recommendation regarding DME provider being responsible for information and training related to equipment placed in their home by hospice. Another suggestion would be reframing the information, i.e., "If a Hospice provides, cleans, and maintains its own</p>

		equipment, the ..." (insert the rest of number (1)). If the Hospice contracts for DME and supplies, the vendor maintains this responsibility.
418.108 Condition of Participation: Short-term inpatient care (pg 40)		We strongly agree with the need to put psychosocial crisis back into this area. We are interdisciplinary because of the multifaceted issues of our care. If we value those things equally, then needing General Inpatient level of care related to a psychosocial, or psycho spiritual crisis would be appropriate. Caregiver breakdown is a huge issue and truly leaves a patient in crisis if the caregiver has been providing for their needs.
418.108 Condition of Participation: Short-term inpatient care (a) Standard: Inpatient care for symptom management and pain control. (pg 40)		Would broaden this description to include psychosocial/psycho spiritual issues as a reason for GIP. Strongly agree that the requirement for an RN to be present providing 24 hour nursing care be dropped. The expertise of the staff needed should be dependant on the needs of the patient. Our hospice visits all GIP's daily so the hospice RN could provide oversight without the facility having to have an RN on board. Further, facilities will misrepresent their actual staffing leading the hospice to be out of compliance, through no real fault of their own.
418.108 Condition of Participation: Short-term inpatient care (b) Standard: Inpatient care for respite purposes. (pg 40)		We strongly support removing the requirement for an RN around the clock for respite patients, as they are placed not for medical needs, but for caregiver relief. Would appreciate more specific guidance as to the frequency of respite per cert period.
418.108 Condition of Participation: Short-term inpatient care (c) Inpatient care provided under arrangements. (pg 40)		We strongly agree with the suggestion that the provider be the custodian of the record with access by hospice or surveyor. It is very difficult to get facilities to follow up post discharge with copies of the record to the hospice provider. It almost requires additional staffing just to monitor this area.
418.110 Condition of Participation: Hospices that provide inpatient care directly (b) Standard: 24 hour nursing services (pg 42)		Please see earlier support for removing this requirement (418.108 (a)).
418.110 Condition of Participation: Hospices that provide inpatient care directly (f) Standard: Patient rooms (pg 45)		We are in agreement with the space requirements outlined to provide sufficient space to families who wish to stay with their loved ones.
418.110 Condition of Participation: Hospices that provide inpatient care directly (m) Standard: Pharmaceutical services. (pg 47)		We strongly agree with allowing pharmaceuticals to be brought from home as long as they are in their original package.
418.110 Condition of Participation: Hospices that provide inpatient care directly (o) Standard: Seclusion and restraint (pg 48)		Please see response for Definitions: Drug restraint at the beginning of this document. Many patients are admitted to GIP level of care related to terminal restlessness or anxiety. In order to keep the patient from harm, restraint may be necessary until the patient can be calmed and medications titrated to symptom management.
418.110 Condition of Participation: Hospices that provide inpatient care directly (o) (3) (ii) (d) (pg 49)		We endorse the suggested changes related to the timeframes when restraints are in use.
418.112 Condition of Participation: Hospices that provide hospice care to residents of a SNF/NF, ICF/MR, or other facilities. (b) Standard: Professional Management (pg 51)		This is a very conflicted area. It often seems that we are in "no win" conflicts with facilities. While hospice is regulated to retain professional management of the patient, facilities show a general lack of disregard for our regulatory requirements. We have the responsibility without the authority to enforce issues with facilities. Facilities are often argumentative when a hospice consult is written on a

		<p>patient on Skilled A days (takes revenue from the facility pocket). The patient may desire hospice instead, and the facilities often REFUSE to allow the patient to elect. Additionally, the hospice and facility regs are often in direct opposition with one another, and facilities fear being cited related to decubitus ulcers, medications, restraints, and poor nutrition, even though hospice is involved. There is very poor interpretation of how the care plan is supposed to be integrated with facilities. Additionally, it is nearly impossible to use a facility, other than a hospital or free-standing inpatient unit, for patients who are confused or agitated and need general inpatient care to control symptoms. Our medication protocols for these symptoms out of control send facilities through the roof with worry and dread about a survey. We make attempt after attempt to be informed of care plan meetings so we can attend, and time after time we are not informed. We have tried calendars to track, but the facilities often change the meetings without notice.</p>
<p>418.112 Condition of Participation: Hospices that provide hospice care to residents of a SNF/NF, ICF/MR, or other facilities. (d) (pg 53)</p>		<p>Communication and coordination of care is already very difficult. This proposed regulation again leaves out the IDT and other facility staff who are more directly related to the care of the patient than the physicians specified. We strongly feel that the Medical Director is a valued member of the IDT, and should not be set apart from the team.</p> <p>We STRONGLY disagree with facility Medical Director(s) serving as the Hospice Medical Director. This opens up the potential for "double dipping" as the facility Medical Director is already being paid for seeing these patients, and then receiving additional reimbursement for hospice patients. Additionally, it sets up potential kickback issues related to referrals only coming to a hospice because the facility medical director is the hospice medical director. In our area, we have seen hospices intentionally hiring facility medical directors with an expected side effect of securing all their referrals. As we look to raise the bar in hospice care, this is one door that should be closed.</p>
<p>418.114 Condition of Participation: Personnel Qualifications for Licensed Professionals. (a) (pg 56)</p>		<p>We support following State guidelines in this area.</p>
<p>418.114 Condition of Participation: Personnel Qualifications for Licensed Professionals. (7) (pg 60)</p>		<p>We think that many small or rural hospices may have difficulty hiring at the MSW level. However, we support following State guidelines for Social Work practice.</p>
<p>418.114 Condition of Participation: Personnel Qualifications for Licensed Professionals. (d) Standard: Criminal Background Checks. (pg 60)</p>		<p>The language is too broad. Suggest adding "independent contractors", otherwise this would imply that anyone who works with Hospice through a contracted arrangement (DME, Pharmacy, etc) would require the hospice performing a background check. We would suggest limiting background checks to those with patient contact, which would include Volunteers (who should be treated as an employee). The time and cost burden of this proposed regulation, could prove very difficult to small or rural hospices.</p>

One additional point of discussion focused around the "burden" these proposed regulations would cause to hospices. We would like for CMS to explain where they pulled the figures from because to our estimation they are not even close to our projected burden. Burden estimates should be derived from polling providers and gauging projections based on provider input.



Missouri Department of Health and Senior Services

P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired 1-800-735-2966 VOICE 1-800-735-2466



Julia M. Eckstein
Director

Matt Blunt
Governor

July 5, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services

Attention: CMS-3844-P

P.O. Box 8010

Baltimore, MD 21244-8010

To Whom It May Concern:

The Missouri Department of Health and Senior Services, Unit of Home Care and Rehabilitative Standards, hospice survey staff, met several days to review and discuss the proposed rule for the hospice regulations. This group consisted of ten surveyors, six of who have been surveying hospices for eight plus years.

Enclosed you will find the compiled comments from the Unit of Home Care and Rehabilitative Standards.

If you should have any questions, I can be reached at 573-751-6336.

Thank you for your consideration of the enclosed comments.

Sincerely,

Lisa Coots, R.N., Administrator
Unit of Home Care and
Rehabilitative Standards

Enclosure

cc Maryalice Futrell, CMS, Kansas City Regional Office

www.dhss.mo.gov

The Missouri Department of Health and Senior Services protects and promotes quality of life and health for all Missourians by developing and implementing programs and systems that provide: information and education, effective regulation and oversight, quality services, and surveillance of diseases and conditions.

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER: Services provided on a nondiscriminatory basis.

FILE CODE: CMS-3844-P

**Medicare and Medicaid Programs Hospice Conditions of Participation;
Proposed Rule
Comments**

418.3 DEFINITIONS:

CLINICAL NOTE: Request addition of psychosocial and spiritual services to this definition. These services are a very important part of hospice care and need to be included in this definition.

Please define: INITIAL ASSESSMENT, COMPREHENSIVE ASSESSMENT
PLAN OF CARE

DRUG RESTRAINT: Recommend the elimination of this definition. We feel this is not applicable to hospice as some medications that may be defined as chemical restraints, in some instances, may be normal patient care protocol in hospice.

EMPLOYEE: The definition states "an employee...who is appropriately trained." We recommend including in the definition "one who has been appropriately trained in death and dying."

LICENSED PROFESSIONAL: Recommend ending the sentence after the word "delivered." Each state may have different requirements and adding "such as" creates limitations.

RESTRAINT: We feel the definition does not define the word *restraint*. A recommendation is being made to delete this definition.

SECLUSION: Recommend deleting this definition for two reasons:

- a. Some patient's want to be secluded at time of death or with severe pain.
- b. The disease process itself could physically prevent the patient from leaving.

418.52 "PATIENT RIGHTS":

(a) Standard: Notice of Rights

- (1) Recommend deletion of the word "language" from the sentence that states, "the hospice must provide the patient or representative with verbal and written notice of the patient's rights and responsibilities in a language and manner the patient understands." We feel it would be too cost prohibitive to have in all languages.
- (3) Recommend deletion based on the following reasons:
 - a. The patient/family receives extensive information during admission and this may become very burdensome.

(3) b. The patient may not be receiving any controlled medications at the time of admission and could be informed at such a time as needed.

(4) Recommend the last part of the sentence be deleted and only state "The hospice must maintain documentation showing that it has complied with the requirements of this section." We feel the agency should state, in their own policy, how this documentation will be accomplished.

(b) Standard: Exercise of rights and respect for property and person

(1) Under (1) we recommend adding a (v) to this standard stating, "has right to Participate in their plan of care."

(4) We recommend deleting (i), (ii), (iii). These are not appropriate for hospice.

(e) Standard: Patient Liability:

The sentence states, " Before care is initiated, the patient must be informed, verbally and in writing, and in a language..." We recommend deletion of the word "language" and replace with the word "manner."

418.54 Comprehensive Assessment of the Patient

(c) Standard: Content of the comprehensive assessment

(1) Please clarify what it is you are asking. If it is the admission diagnosis, we recommend just asking for the diagnosis.

(2) Please clarify what it is you are asking. Are you asking for morbidity & comorbidity factors? Are you asking for social or economical barriers? These first two questions do not seem to be clearly worded.

(3) (i) We are wondering why other important issues for the hospice patient are not addressed in as much detail as "bereavement" is here.

"ASSESSMENT TIME FRAMES"

(d) Standard: Update of the comprehensive assessment

Please clarify. Are you proposing the comprehensive assessment, encompassing all disciplines, be done every 14 days? Or is it the ongoing plan of care derived from the comprehensive assessment on admission with an update at recertification time?

(1) If the language is meant to describe a comprehensive assessment, it is our recommendation that it be updated every recert period & not every 14 days. We do feel the ongoing plan of care needs to be updated every 14 days.

418.56 Interdisciplinary group care planning and coordination of services

(a) Standard: Approach to service delivery

(1) We recommend changing “qualified health care professional” to “registered nurse”. We feel it should be the RN that coordinates the patient’s care.

(i) We recommend changing to....”A doctor of medicine or osteopathy (who may or may not be the patient’s attending physician).

“PLAN OF CARE”

(b) Standard: Plan of care

We recommend there should be a time frame as to when the plan of care needs to be completed.

(c) Standard: Content of the plan of care

Please clarify. Are you expecting a complete comprehensive assessment by all disciplines every two weeks as well as updating the plan of care every two weeks? Our recommendation is to update the plan of care every two weeks or anytime a change in the patient’s condition occurs. It’s unrealistic that a full comprehensive assessment is to be done every two weeks by all disciplines. Not all hospice patients may want or need all disciplines every two weeks.

(2) We would recommend deleting the part of the sentence saying “a detailed statement of”. It should be adequate just to say “The scope and frequency of services.....”

(6) Would recommend changing “patient and family” to “patient/family”.

(d) Standard: Review of the plan of care

We recommend the following:

- “The medical director or physician designee” be deleted and the sentence start with “The hospice interdisciplinary team...” (The reason for this is that the medical director is part of the interdisciplinary team.)
- “...at intervals specified in the plan” be deleted. The plan of care cannot forecast or project the patient’s needs or change in condition.
- Delete “updated comprehensive assessment”. Change to “a revised plan of care must include information from the patient’s ongoing assessment....”

“COORDINATION OF SERVICES”

(e) Standard: Coordination of services

(1) We recommend deleting “through its designated professionals”. The interdisciplinary group has already been defined, thus, we feel this is not necessary.

- (4) For clarity purposes, we recommended changing this to “Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether provided directly or under arrangement.

“QAPI”

418.58 Quality assessment and performance improvement

We have a general comment for this entire condition. We feel the standards under this condition are very “wordy” and unclear making it difficult to even comment. It seems Standard (c) with the addition of “data collection” could encompass and a QA program. From a surveyor perspective we feel these would be very difficult to enforce when we don’t even understand them.

(d) Standard: Performance improvement projects

- (1) Please define what is meant by “scope of distinct improvement projects”. Define what “complexity” is.

418.64 Core Services

(b) Standard: Nursing services

- (2) Please clarify NP. Is the NP an employee of the hospice or the attending Physician?

(d) Standard: Counseling services

- (3) Spiritual counseling
- (iii) It is our recommendation that if the hospice is not required to go to extraordinary lengths to do this than the sentence should be deleted.

“STATUTORY NURSING WAIVER”

418.66 Nursing Services – Waiver of requirement that substantially all nursing services be routinely provided directly by a hospice.

- (a) (1) We recommend changing the sentence to include both rural and urban areas.

418.72 Physical therapy, occupational therapy, and speech-language pathology

We recommend adding dietitians to the non-core services.

418.76 Home health aide and homemaker services

(c) Standard: Competency evaluation.

Recommend adding the word "aide" after home health. The sentence should read "An individual may furnish home health aide services"

(e) Standard: Qualifications for instructors conducting classroom supervised practical training, competency evaluations and in-service training.

We recommend that qualifications should be "two years of nursing experience, at least one year of which must be in hospice care".

GENERAL COMMENT: All places in the document that states home health aide or home health agency should read hospice aide or hospice agency.

(f) Standard: Eligible training organization

Recommend changing "home health agency" to "hospice agency".

(2) Change from home health to "hospice".

(3) We recommend deleting this. It does not relate to hospice but instead relates to home health. There are no partial or extended surveys for hospice.

(4) Please explain. Is there a monetary penalty of \$5000 for hospice?

(5) Change home health agency to "hospice agency".

(7)(ii) Again, can hospice be assessed this type of penalty?

(iv) Change home health to hospice

(g) Standard: Home health aide assignments and duties

We recommend removing "qualified therapist". In hospice care, the therapist does not visit as often as nursing does.

(1) We recommend to delete "or qualified therapist". We think it should read "hospice aides are assigned to a specific patient by a registered nurse. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section."

(2) Change home health to hospice.

(i) We recommend deleting this statement. It is our feeling that the IDT should have authority to decide when a patient needs hospice aide.

(3) (iv) We recommend adding, "as permitted by state law".

(4) Recommend deleting "or other appropriate licensed professional".

(h) Standard: Supervision of home health aides
Again, change home health to "hospice".

- (1) Recommend deleting "or qualified therapist"
- (2) Recommend deleting "or therapist"
 - (i) Delete "or qualified therapist"

WE RECOMMEND TO ADD:

- (3) When an aide is permanently assigned to a licensed hospice facility, the every 2-week supervisory requirement does not apply, however, there must be evidence of an annual performance review in the aide's personnel file.

"ORGANIZATION AND ADMINISTRATION"

418.100 Organization and administration of services

(c) Standard: Services

- (1) (vii) Please clarify "short term" i.e., respite vs. acute.

WE RECOMMEND TO ADD:

- (ix) Continuous care

WE ALSO RECOMMEND TO ADD:

- (3) Each hospice shall provide initial orientation for each direct employee that is specific to the employee's job duties.

(e) Standard: Professional management responsibility

Recommend to delete "of staff and". The hospice agency is not responsible for staff of another agency

- (2) Recommend changing to "Furnished in a safe and effective manner by qualified personnel."

(g) Standard: In-service training

Recommend deleting "as necessary".

418.102 "MEDICAL DIRECTOR"

We recommend deleting the last sentence because this is the responsibility of the IDT, which include the medical director, attending physician and other health care professionals.

(a) Standard: Initial certification of terminal illness

The attending physician has been excluded from this initial certification. We recommend changing it to say, "The attending physician and medical director or physician designee reviews...."

(b) Standard: Recertification of the terminal illness

418.21(a) does this reference the BBA of 1997 (Aug 5, 1997)? Is this the correct recertification timeframes?

(c) Standard: Coordination of medical care

We recommend changing "patient's medical care in its entirety" to read "patient's medical and hospice care". We also recommend deleting the last sentence.

418.104 "CLINICAL RECORDS"

(a) Standard: Each patient's record must include the following:

- (1) Explain. Why would you expect updated comprehensive assessment and not an updated plan of care? We recommend that it read: "The initial plan of care, revisions to plan of care, initial assessments, comprehensive assessments at recertification, clinical notes." As a surveyor team, we find that the progress notes is a repetition. If plans of care are updated appropriately there should be no need for progress notes.

"DRUGS, SUPPLIES, & DME"

418.106 Drugs, controlled drugs and biologicals, medical supplies, and durable medical equipment

(b) Standard: Controlled drugs in the patient's home

Recommend rewriting to say, "The hospice must have a written policy for delivery and disposing of controlled drugs maintained in the patient's home."

It is our recommendation to delete the rest of the statement. We feel tracking and collecting does not apply to hospice. We do feel that education of patient and family regarding controlled medications needs to be done and documented but all the rest of the information stated here is not appropriate for hospice.

(c) Standard: Use and maintenance of equipment and supplies

- (1) We recommend changing this entire paragraph to the "suggested language" in the comment column.

418.108 "SHORT-TERM INPATIENT CARE"

(a) Standard: Inpatient care for symptom management and pain control

- (2) Please clarify "nursing services". Is this RN or LPN?

(c) Standard: Inpatient care provided under arrangements

- (3) We feel a copy of the medical record is not necessary. A copy of the discharge summary would be sufficient.

"INPATIENT CARE"

418.110 Hospices that provide inpatient care directly

(b) Standard: Twenty-four hour nursing services

Please clarify "nursing services".

(f) Standard: Patient rooms

(4) (v) We recommend to change to 100 sq feet for each residing patient whether it is a single or double room.

(m) Standard: Pharmaceutical services

We recommend deleting: "Drugs and biologicals must be obtained from community or institutional pharmacists or stocked by the hospice."

(o) Standard: ***"SECLUSION AND RESTRAINT"***

GENERAL COMMENT ON THE ENTIRE STANDARD:

It is our feeling that a "Hospice House" environment is so different than a nursing home or hospital. Other than for safety reasons we cannot fathom using restraints or seclusion on a hospice patient. Therefore, we feel we cannot comment on this section.

"RESIDENTS RESIDING IN A FACILITY"

418.112 Hospices that provide hospice care to residents of a SNF/NF, ICF/MR, or other facilities.

(c) Standard: Core Services

We recommend adding medical director or physician designee.

(d) Standard: Medical Director

We recommend it to read, "The medical director or physician designee of the hospice must provide overall coordination of the medical care of the hospice resident that resides in an SNF, NF, or other facility." We recommend deleting the last sentence. We feel this leaves out the IDT team concept.

(e) Standard: Written agreement

(1) Why would this be part of a contract? Shouldn't it be part of the patient clinical record?

(4) (i) This would require a change in the plan of care

(ii) This says the same thing as (i). Why not combine?

(iii) Recommend to delete. Hospice takes care of the dying.

(g) Standard: Coordination of services

(1) Recommend to add " and updates of plan of care".

(h) Standard: Transfer, revocation, or discharge from hospice

Recommend changing "does not directly impact" to "may not directly impact".

(i) Standard: This standard needs to be **ALSO** added to subpart D 418.100 – Condition of Participation: Organization and administration of services. (DO NOT DELETE FROM THIS SECTION).

“PERSONNEL QUALIFICATIONS”

418.114 Personnel qualifications for licensed professionals

(b) Any place that states “home health aide” should state “hospice aide”

“SOCIAL WORK”

(c) (7) We recommend that a bachelor’s degree in social work or related field (psychology, counseling, etc.) should be considered.

June 21, 2005
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-3844-P



Dear Sirs:

GENERAL:

With commitment to interfaith ministry and the professional practice of pastoral care, the Association of Professional Chaplains serves chaplains in all types of health and human service settings. Almost 4,000 members are chaplains involved in pastoral care, representing more than 150 faith groups. As a national, not-for-profit professional association, the APC advocates for quality spiritual care of all persons in healthcare facilities, correctional institutions, long term care units, rehabilitation centers, hospice, the military, and other specialized settings. For more information about the APC or further information regarding our comments below, visit our website at <http://www.professionalchaplains.org>, or contact our Executive Director, Jo Schrader, at 847-240-1014.

SPIRITUAL NEEDS OF HOSPICE PATIENTS AND FAMILIES

We applaud CMS's awareness of and commitment to the inclusion of meeting the spiritual and emotional needs of hospice patients and families and a part of patient rights and the continuum of care. We would encourage the acknowledgement that spiritual needs, just as medical, social, physical, and psychosocial needs, depends upon the delivery of outcome-based, patient centered care by trained and certified professionals who are specialists in spirituality. While the proposed rules identify 'spiritual needs' and 'spiritual counseling', what is lacking is more specific standards regarding who is qualified to provide these services. The proposed rules, in the use of terms such as "clergy", which is a specifically Christian term, fails to acknowledge and provide care for the needs of patients of other religious and spiritual traditions, and we would encourage CMS to utilize language that is more inclusive. We would also encourage CMS to acknowledge the importance of providing for patient and family cultural needs, of which spiritual and religious needs are, while essential, only one part of a person's culture. There are no specific standards within the rules that require hospices to assess and be attentive and sensitive to cultural needs, such as dietary, space, and treatment.

**LICENSED PROFESSIONAL SERVICES
PROPOSED 418.62**

PROFESSIONAL SPIRITUAL CARE PROVIDERS

The proposed hospice rules contain specific standards for licensed professional services. We understand the rationale for basing these upon State standards for those in other healthcare

professions, such as physicians, nurses, therapists, medical social workers, home health aides, etc. However, professional spiritual care providers are board certified by national professional groups, and we would encourage that the proposed rules include this requirement of those providing spiritual care and counseling in all hospice settings. We have attached a copy of the Common Standards for Professional Chaplaincy, adopted by the Council on Collaboration in 2004, which provides a unified voice of the six primary professional spiritual care groups in the United States and Canada. The membership of these groups represents over 10,000 members who currently serve as chaplains, pastoral counselors, and clinical pastoral educators in specialized settings, including hospice and other healthcare organizations, counseling centers, prison, or the military.

In summary, Board Certified chaplains are required to possess:

- An undergraduate degree and a graduate-level theological degree from a college, university, or theological school accredited by a member of the Council of Higher Education Accreditation
- A minimum of 4 units (requiring 1600 hours of training) of Clinical Pastoral Education, which is nationally recognized clinical training in the provision of professional spiritual care
- Board certification by a national professional pastoral care cognate group by which the chaplain demonstrates competencies in pastoral theology and care, personal and professional identify and conduct, and commitment to a Code of Professional Ethics
- Continued professional development by active participation in membership of a cognate group through the payment of dues, professional continuing education, and peer review

In addition, professional spiritual care providers are required to abide by a Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators, and Students, also a foundational document affirmed by the previously defined Council on Collaboration. We have also attached this document. By including standards that require the employment of Board Certified spiritual care professionals, the proposed CMS Rules would ensure that those providing spiritual care to hospice patients, families, and staff would be held accountable just as other professional, licensed staff are. This protects hospice patients, family, and staff with unwanted, intrusive, and potentially abusive spiritual interventions by those who are not professionally trained, certified, nor held accountable to professional standards of practice and ethics.

While community religious leaders provide gifts in the provision of religious care to hospice patients and families, professionally trained and certified spiritual care providers bring to the hospice environment the skills to provide spiritual assessment, an outcome-based spiritual plan of care and interventions based on professional spiritual care standards of practice, the ability to work effectively within an interdisciplinary team, and specialty in loss, grief, and bereavement care and counseling. Board certified chaplains work with community religious leaders to facilitate their care to their religious community members, while also serving as an educator and

facilitator of the hospice environment and specialist in the unique spiritual and emotional needs of hospice patients and families.

We recommend that standards be included to require hospices to employ trained and certified professional chaplains in order to meet clearly and effectively the proposed rules including:

Proposed 418.52: PATIENT RIGHTS

Professionally trained and nationally certified spiritual care providers are advocates for patient rights, educators for patients, families, and hospice staff, and are trained to provide spiritual care to those seeking to make treatment and end of life decisions.

Proposed 418.54: COMPREHENSIVE ASSESSMENT OF THE PATIENT

Board certified chaplains are trained to provide spiritual assessments that identify issues, interventions, and specific outcomes to meet the unique needs of each hospice patient and their family. Additionally, board certified chaplains are trained in how to document in both clinical and progress notes in ways that articulate clearly to the entire interdisciplinary team what spiritual issues may impact the overall care of the patient and family. Professional chaplains are guided by and adhere to national standards of practice in assessment, interventions regarding spiritual distress, loss, bereavement, coping, and the use of religious and spiritual resources identified by the patient and family.

Proposed 418.56: PLAN OF CARE AND COORDINATION OF SERVICES

Professionally trained and nationally trained spiritual care providers have extensive training and experience in developing and writing an outcome-based written spiritual plan of care for patients and families and working with interdisciplinary group care planning and coordination of services.

Proposed 418.58: QAPI

Board certified chaplains not only have training in quality assessment and performance improvement, but also have shown value to organizations that they serve in actively participating and maintaining QI and PI planning and projects. All work of board certified chaplains is informed and guided by professional practice standards applicable to hospice care.

Proposed 418.78 VOLUNTEERS

Clinically trained and nationally certified professional spiritual care providers are skilled in the training and oversight of volunteers, particularly those who seek to provide emotional and spiritual care to hospice patients and families. Having a board certified chaplain in this role assures the hospice of maintaining patient rights and providing appropriate care by volunteers.

Proposed 418.100 ORGANIZATION AND ADMINISTRATION

Again, board certified chaplains are trained and professionally credentialed and follow national standards of practice in order to organize, manage, and administer spiritual services to patients, caregivers, and families within the hospice environment while maintaining dignity, comfort, and

advocacy for patient/family needs and desires. Board certified chaplains serve as educators to other professional staff and volunteers in areas of patient rights, advance care planning, end of life, and spiritual, religious, and cultural needs.

INCLUSIVE SPIRITUAL AND RELIGIOUS LANGUAGE

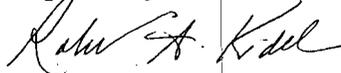
We strongly encourage the Proposed Rules be adapted to utilize language that is inclusive of persons of all spiritual and religious traditions. Rather than using the word 'clergy' in the Proposed Rules, we suggest the use of the word "Board Certified Chaplain" for those employed by the hospice and "community religious leaders" for those who serve as community support and/or volunteers.

CULTURAL ISSUES

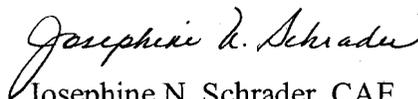
We also strongly encourage that the proposed rules be attentive in the inclusion of additional language addressing the cultural needs of patients and families. It is important to all patients, especially when dealing with the stresses of a terminal diagnosis and end of life, that their rights be respected in all areas of life. For many of differing cultural and spiritual backgrounds, the issues of diet, space for cultural, spiritual, and/or religious ritual, medication and other treatments, the inclusion of complementary therapies, and conversations around diagnosis, treatment, and death are essential dimensions of patient rights.

Thank you for this opportunity for us to comment on CMS-3844-P, the new proposed rules for hospice and for your consideration of our concerns. Do not hesitate to contact the Association of Professional Chaplains if we can provide more information regarding the training, certification, standards of practice, and work of professional chaplains.

Respectfully submitted,



Robert A. Kidd, M.Div. BCC
President



Josephine N. Schrader, CAE
Executive Director

ATT: Common Standards for Professional Chaplaincy
Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators, and
Students

Common Standards for Professional Chaplaincy

This document is one of four foundational documents affirmed by the constituent boards of the Council on Collaboration on November 7, 2004 in Portland, Maine. Collectively, these documents establish a unified voice for the six organizations that have affirmed them and describe what it means to these organizations to be a professional pastoral care provider, pastoral counselor or educator. The four documents are:

- Common Standards for Professional Chaplaincy
- Common Standards for Pastoral Educators/Supervisors
- Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students
- Principles for Processing Ethical Complaints

The membership of the participating groups represents over 10,000 members who currently serve as chaplains, pastoral counselors, and clinical pastoral educators in specialized settings as varied as healthcare, counseling centers, prisons or the military. The complete documents and information about each of the collaborating groups can be found on the following websites:

- Association of Professional Chaplains (APC)
www.professionalchaplains.org
- American Association of Pastoral Counselors (AAPC)
www.aapc.org
- Association for Clinical Pastoral Education (ACPE)
www.acpe.edu
- National Association of Catholic Chaplains (NACC)
www.nacc.org
- National Association of Jewish Chaplains (NAJC)
www.najc.org
- Canadian Association for Pastoral Practice and Education (CAPPE/ACPEP)
www.cappe.org

For more information on the foundations of professional pastoral care see "*Professional Chaplaincy: Its Role and Importance in Healthcare*" available at <http://www.professionalchaplains.org/professional-chaplain-services-resources-reading-room-hc-role.htm>

Qualifications of Professional Chaplaincy

The candidate for certification must:

- QUA1: Provide documentation of current endorsement or of good standing in accordance with the requirements of his/her own faith tradition.
- QUA2: Be current in the payment of the professional association's annual dues.
- QUA3: Have completed an undergraduate degree from a college, university, or theological school accredited by a member of the Council for Higher Education Accreditation (www.chea.org); and a graduate-level theological degree from a college, university or theological school accredited by a

member of the Council for Higher Education Accreditation. Equivalencies for the undergraduate and/or graduate level theological degree will be granted by the individual professional organizations according to their own established guidelines.

QUA4: Provide documentation of a minimum of four units of Clinical Pastoral Education (CPE) accredited by the Association for Clinical Pastoral Education (ACPE), the United States Conference of Catholic Bishops Commission on Certification and Accreditation, or the Canadian Association for Pastoral Practice and Education (CAPPE/ACPEP). Equivalency for one unit of CPE may be considered.

Section I: Theory of Pastoral Care

The candidate for certification will demonstrate the ability to:

- TPC1: Articulate a theology of spiritual care that is integrated with a theory of pastoral practice.
- TPC2: Incorporate a working knowledge of psychological and sociological disciplines and religious beliefs and practices in the provision of pastoral care.
- TPC3: Incorporate the spiritual and emotional dimensions of human development into the practice of pastoral care.
- TPC4: Incorporate a working knowledge of ethics appropriate to the pastoral context.
- TPC5: Articulate a conceptual understanding of group dynamics and organizational behavior.

Section II: Identity and Conduct

The candidate for certification will demonstrate the ability to:

- IDC1: Function pastorally in a manner that respects the physical, emotional, and spiritual boundaries of others.
- IDC2: Use pastoral authority appropriately.
- IDC3: Identify one's professional strengths and limitations in the provision of pastoral care.

- IDC4: Articulate ways in which one's feelings, attitudes, values, and assumptions affect one's pastoral care.
- IDC5: Advocate for the persons in one's care.
- IDC6: Function within the Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students
- IDC7: Attend to one's own physical, emotional, and spiritual well-being.
- IDC8: Communicate effectively orally and in writing.
- IDC9: Present oneself in a manner that reflects professional behavior, including appropriate attire and personal hygiene.

Section III: Pastoral

The candidate for certification will demonstrate the ability to:

- PAS1: Establish, deepen and end pastoral relationships with sensitivity, openness, and respect.
- PAS2: Provide effective pastoral support that contributes to well-being of patients, their families, and staff.
- PAS3: Provide pastoral care that respects diversity and differences including, but not limited to culture, gender, sexual orientation and spiritual/religious practices.
- PAS4: Triage and manage crises in the practice of pastoral care.
- PAS5: Provide pastoral care to persons experiencing loss and grief.
- PAS6: Formulate and utilize spiritual assessments in order to contribute to plans of care.
- PAS7: Provide religious/spiritual resources appropriate to the care of patients, families and staff.
- PAS8: Develop, coordinate and facilitate public worship / spiritual practices appropriate to diverse settings and needs.
- PAS9: Facilitate theological reflection in the practice of pastoral care.

Section IV: Professional

The candidate for certification will demonstrate the ability to:

- PRO1: Promote the integration of Pastoral / Spiritual Care into the life and service of the institution in which it resides.
- PRO2: Establish and maintain professional and interdisciplinary relationships.
- PRO3: Articulate an understanding of institutional culture and systems, and systemic relationships.
- PRO4: Support, promote, and encourage ethical decision-making and care.
- PRO5: Document one's contribution of care effectively in the appropriate records.
- PRO6: Foster a collaborative relationship with community clergy and faith group leaders.

Requirements for the maintenance of certification

In order to maintain status as a Certified Chaplain, the chaplain must:

- MNT1: Participate in a peer review process every fifth year.
 - MNT2: Document fifty (50) hours of annual continuing education.
(Recommendation that personal therapy, spiritual direction, supervision, and/or peer review be an acceptable options for continuing education hours.)
 - MNT3: Provide documentation every fifth year of current endorsement or of good standing in accordance with the requirements of his/her own faith tradition.
 - MNT4: Be current in the payment of the professional association's annual dues.
 - MNT5: Adhere to the Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students.
-

Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students

hereinafter referred to as: Spiritual Care Professionals

This document is one of four foundational documents affirmed by the constituent boards of the Council on Collaboration on November 7, 2004 in Portland, Maine. Collectively, these documents establish a unified voice for the six organizations that have affirmed them and describe what it means to these organizations to be a professional pastoral care provider, pastoral counselor or educator. The four documents are:

- Common Standards for Professional Chaplaincy
- Common Standards for Pastoral Educators/Supervisors
- Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students
- Principles for Processing Ethical Complaints

The membership of the participating groups represents over 10,000 members who currently serve as chaplains, pastoral counselors, and clinical pastoral educators in specialized settings as varied as healthcare, counseling centers, prisons or the military. The complete documents and information about each of the collaborating groups can be found on the following websites:

- Association of Professional Chaplains (APC)
www.professionalchaplains.org
- American Association of Pastoral Counselors (AAPC)
www.aapc.org
- Association for Clinical Pastoral Education (ACPE)
www.acpe.edu
- National Association of Catholic Chaplains (NACC)
www.nacc.org
- National Association of Jewish Chaplains (NAJC)
www.najc.org
- Canadian Association for Pastoral Practice and Education (CAPPE/ACPEP)
www.cappe.org

For more information on the foundations of professional pastoral care see "*Professional Chaplaincy: Its Role and Importance in Healthcare*" available at <http://www.professionalchaplains.org/professional-chaplain-services-resources-reading-room-hc-role.htm>.

The Code of Ethics for Spiritual Care Professionals:

- gives expression to the basic values and standards of the profession;
- guides decision making and professional behavior;
- provides a mechanism for professional accountability; and
- informs the public as to what they should expect from Spiritual Care Professionals.

Preamble

Spiritual Care Professionals are grounded in communities of faith and informed by professional education and training.

They are called to nurture their personal health of mind, body and spirit and be responsible for their personal and professional conduct as they grow in their respect for all living beings and the natural environment.

When Spiritual Care Professionals behave in a manner congruent with the values of this code of ethics, they bring greater justice, compassion and healing to our world.

Spiritual Care Professionals:

- affirm the dignity and value of each individual;
- respect the right of each faith group to hold to its values and traditions;
- advocate for professional accountability that protects the public and advances the profession; and
- respect the cultural, ethnic, gender, racial, sexual-orientation, and religious diversity of other professionals and those served and strive to eliminate discrimination.

1.0 Ethical Principles in Relationships with Clients

Spiritual Care Professionals understand clients to be any counselees, patients, family members, students or staff to whom they provide spiritual care. In relationships with clients, Spiritual Care Professionals uphold the following standards of professional ethics. Spiritual Care Professionals:

- 1.1 Speak and act in ways that honor the dignity and value of every individual.
- 1.2 Provide care that is intended to promote the best interest of the client and to foster strength, integrity and healing.
- 1.3 Demonstrate respect for the cultural and religious values of those they serve and refrain from imposing their own values and beliefs on those served.
- 1.4 Are mindful of the imbalance of power in the professional/client relationship and refrain from exploitation of that imbalance.
- 1.5 Maintain relationships with clients on a professional basis only.

- 1.6 Avoid or correct any conflicts of interest or appearance of conflicting interest(s).
- 1.7 Refrain from any form of sexual misconduct, sexual harassment or sexual assault in relationships with clients.
- 1.8 Refrain from any form of harassment, coercion, intimidation or otherwise abusive words or actions in relationships with clients.
- 1.9 Safeguard the confidentiality of clients when using materials for educational purposes or written publication.
- 1.10 Respect the confidentiality of information entrusted to them by clients when communicating with family members or significant others except when disclosure is required for necessary treatment, granted by client permission, for the safety of any person or when required by law.
- 1.11 Understand the limits of their individual expertise and make referrals to other professionals when appropriate.

2.0 Ethical Principles in Relationships Between Supervisors/Educators and Students

Spiritual Care Professionals respect the integrity of students using the power they have as supervisors/educators in responsible ways. Spiritual Care Professionals:

- 2.1 Maintain a healthy educational environment free of coercion or intimidation.
- 2.2 Maintain clear boundaries in the areas of self-disclosure, intimacy and sexuality.
- 2.3 Provide clear expectations regarding responsibilities, work schedules, fees and payments.
- 2.4 Provide adequate, timely and constructive feedback to students.
- 2.5 Maintain a healthy respect for the personal growth of students and provide appropriate professional referrals.
- 2.6 Maintain appropriate confidentiality regarding all information and knowledge gained in the course of supervision.

3.0 Ethical Principles in Relationships with Faith Community

Spiritual Care Professionals are accountable to their faith communities, one another and other organizations. Spiritual Care Professionals:

- 3.1 Maintain good standing in their faith group.
- 3.2 Abide by the professional practice and/or teaching standards of the state/province, the community and the institution in which they are employed. If for any reason a Spiritual Care Professional is not free to practice or teach according to conscience, the Spiritual Care Professional shall notify the employer, his or her professional organization and faith group as appropriate.
- 3.3 Do not directly or by implication claim professional qualifications that exceed actual qualifications or misrepresent an affiliation with any institution.

4.0 Ethical Principles in Relationships with Other Professionals and the Community

Spiritual Care Professionals are accountable to the public, faith communities, employers and professionals in all professional relationships. Spiritual Care Professionals:

- 4.1 Promote justice in relationships with others, in their institutions and in society.
- 4.2 Represent accurately their professional qualifications and affiliations.
- 4.3 Exercise good stewardship of resources entrusted to their care and employ sound financial practices.
- 4.4 Respect the opinions, beliefs and professional endeavors of colleagues and other professionals.
- 4.5 Seek advice and counsel of other professionals whenever it is in the best interest of those being served and make referrals when appropriate.
- 4.6 Provide expertise and counsel to other health professionals in advocating for best practices in care.
- 4.7 Seek to establish collaborative relationships with other community and health professionals.
- 4.8 Advocate for changes in their institutions that would honor spiritual values and promote healing.

- 4.9 Provide other professionals with chart notes where they are used that further the treatment of the clients or patients, obtaining consent when required.
- 4.10 Communicate sufficient information to other care team members while respecting the privacy of clients.
- 4.11 Ensure that private conduct does not impair the ability to fulfill professional responsibilities or bring dishonor to the profession.
- 4.12 Clearly distinguish between statements made or actions taken as a private individual and those made as a member or representative of one of the cognate organizations.

5.0 Ethical Principles in Relationships with Colleagues

Spiritual Care Professionals engage in collegial relationships with peers, other chaplains, local clergy and counselors, recognizing that perspective and judgment are maintained through consultative interactions rather than through isolation. Spiritual Care Professionals:

- 5.1 Honor all consultations, whether personal or client-related, with the highest professional regard and confidentiality.
- 5.2 Maintain sensitivity and professional protocol of the employing institution and/or the certifying organization when receiving or initiating referrals.
- 5.3 Exercise due caution when communicating through the internet or other electronic means.
- 5.4 Respect each other and support the integrity and well being of their colleagues.
- 5.5 Take collegial and responsible action when concerns about or direct knowledge of incompetence, impairment, misconduct or violations against this code arise.
- 5.6 Communicate sufficient information to other care team members while respecting the privacy of clients.

6.0 Ethical Principles in Advertising

Spiritual Care Professionals engage in appropriate informational activities that educate the public about their professional qualifications and individual scopes of practice. Spiritual Care Professionals:

- 6.1 Represent their competencies, education, training and experience relevant to their practice of pastoral care, education and counseling in an accurate manner.
- 6.2 Do not use any professional identification (business cards, letterhead, Internet or telephone directory, etc.) if it is false, misleading, fraudulent or deceptive.
- 6.3 List and claim as evidence only degrees and certifications that are earned from educational institutions and/or training programs recognized by the certifying organizations of Spiritual Care Professionals.
- 6.4 Ascertain that the qualifications of their employees, supervisees and students are represented in a manner that is not false, misleading, fraudulent or deceptive.
- 6.5.1 Represent themselves as providing specialized services only if they have the appropriate education, training or supervised experience.

7.0 Ethical Principles in Research

Spiritual Care Professionals engaging in research follow guidelines and applicable laws that strive to protect the dignity, privacy and well-being of all participants. Spiritual Care Professionals:

- 7.1 Engage only in research within the boundaries of their competence.
- 7.2 In research activities involving human participants, are aware of and ensure that the research question, design and implementation are in full compliance with ethical principles.
- 7.3 Adhere to informed consent, including a clear and understandable explanation of the procedures, a description of the risks and benefits, and the duration of the desired participation.
- 7.4 Inform all participants of the right to withdraw consent and to discontinue involvement at any time.
- 7.5 Engage in research while being sensitive to the cultural characteristics of participants.
- 7.6 Maintain the confidentiality of all research participants and inform participants of any limits of that confidentiality.
- 7.7 Use any information obtained through research for professional purposes only.

7.8 Exercise conscientiousness in attributing sources in their research and writing thereby avoiding plagiarism.

7.9 Report research data and findings accurately.

Hospice of the South Shore

100 Bay State Drive
P.O. Box 859060
Braintree, MA 02185-9060

4
(800) 432-9995
(781) 843-0947
TDD/TYY: (781) 794-7829

July 7, 2005

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-3844-P
PO Box 8010
Baltimore, MD 21244-8010

Dear Sir/Madam:

I appreciate this opportunity to comment on the Medicare and Medicaid Programs: Hospice Conditions of Participation; Proposed Rule, which appeared in the Federal Register on May 27, 2005. Hospice of the South Shore is a non-profit hospital based hospice serving 22 towns and approximately 450 terminally ill patients per year.

After reviewing the proposed changes there are several comments that I need to share along with the impact several of the proposed changes.

148.54 Comprehensive assessment of the patient-

The requirement for assessment within 24 hours is not a practical standard. With the short length of stay our acuity is high and the care intensive. Most of our patients require more nursing visits now than in previous years, and along with vacancies, diminishes the ability to meet the 24-hour standard. Our current practice is to contact every patient or family the day the referral is received to introduce ourselves and set up an appointment time. Often times the patient or family is not ready for the admission within 24 hours but welcome the phone contact as an initial step. I am requesting that the 24-hour comprehensive admission be removed and the language changed to "contact" within 24 hours which is a more reasonable and achievable standard. We make every effort to admit every patient in a rapid and timely manner and have more "same day admissions" requests which are done on a 24 hour basis. I ask for your consideration on the impact this standard would impose on hospices.

418.76 Home health aide and homemaker services-

Supervision of HHA standard is a bit confusing and I would appreciate some clarification on the intent. For hospices to physically supervise each HHA involved in the patient's care would be an operational challenge as many patients have multiple HHA's involved in their care.

Hospice of the South Shore

100 Bay State Drive
P.O. Box 859060
Braintree, MA 02185-9060

(800) 432-9995
(781) 843-0947
TDD/TTY: (781) 794-7829

418.100 Organization and administration of services-

I am requesting a change in the language form "consistent with patient and family needs and desires to "consistent with the patient's goals." The proposed change suggests an opportunity for unrealistic treatment and interventions and, in addition, the patient's wishes and preferences should be the priority where there are conflicts in the family.

494.102 Medical Director-

Coordination of medical care- it is not a realistic expectation nor is it appropriate for a Medical Director to be responsible for directing the hospice's QA/PI programs. Many hospices, mine included, are very part time and do not have the knowledge to undertake this task. The medical director is utilized on a part time basis for IDT involvement, clinical consultations, and certifications.

418.108 Short term inpatient care-

General Inpatient level of care needs to have an RN on site 24 hours a day as this is a highly intense level of care. The 24-hour requirement should be removed from the Respite Care level.

418.112 Hospice in the SNF-

Medical Director-The proposed requirement for the hospice medical director attending physician SNF medical director and other physicians is not realistic, is time consuming and frankly would not occur. This requirement would restrict access for patients, as the physicians involved would find this burdensome. Physicians are always encouraged to be involved in patient care and communicate effectively as needed to all members of the team.

Thank you in advance for your time and willingness to revisit the proposed changes.

Sincerely,

Mary Beth Barry RN, MSM, CHPN

Mary Beth Barry RN, MSM, CHPN
Director
Hospice of the South Shore

Northwest Healthcare Alliance, Inc.

July 16, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-3844-P
PO Box 8010
Baltimore, MD 21244-8010

Via Certified Mail
7002-0510-0003-6046-0383

**Re: CMS-3844-P
Proposed Rule to 42 CFR Part 418**

Hospice Conditions of Participation

This letter is respectfully submitted in response to the Proposed Rule regarding changes to the Hospice Conditions of Participation.

In this response, I will focus on one aspect of an area that appears to be neglected in this proposal but that needs to be addressed in order to prevent abuses to patients and to the Medicare Program, as well as, to achieve the desired quality improvement and that is **“patient choice.”**

The Importance of this Rule

In the Introduction it was stated that CMS has historically adopted an *“approach that has been directed toward identifying health care providers that furnish poor quality care or fail to meet minimum Federal standards.”* As providers, we never cease to be amazed by the lack of understanding at the Federal level of the abuses that go unchecked daily until they become so big that they can no longer be ignored and then the OIG takes action. That action is always late; long after the damage has been done to patients, providers, communities, taxpayers and the Program. The headlines of the past ten years of the billions assessed against hospital chains, therapy chains, home health chains, national hospice chains, not for profit providers and unscrupulous physicians attest to the unrelenting tide of greedy operators in the Medicare Program.

Many providers know of violations and abuses by other providers but don't want to get involved, the so called, “Good old’ boys (or girls) club.” Some of the national associations that depend on provider assessments and dues to pay their executives and employees salaries and benefits, are reluctant to take a position on **“patient choice”** or other potential abuse areas for fear of losing their income stream from the providers who rely on **“patient steering.”** And so we all regard the efforts of CMS and the OIG to chase down the rogues much like drivers gawking at the car accident on the side of the highway with several well lit police cars providing a barrier. A more humorous analogy

Assured Home Health, Hospice, Home Care and Medical Staffing

P.O. Box 610 • Woodinville, WA 98072-0610
Phone (206) 907-0580 • Fax (425) 483-2044
Web Site: www.assurednw.com

July 16, 2005

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is viewing CMS and the OIG as Wiley Coyote chasing but never catching the Road Runner, no matter what devilish instrument he employs. We do not understand the mentality of "catching them doing something wrong" and it appears from the words used in the introduction and the resultant rule changes and proposals that CMS is finally beginning to understand the problem. However, it does not go far enough.

Patients have a right to choose their providers in the Medicare Program. That right is fundamental to our American heritage and is guaranteed in the Social Security Act, Section 1802 (a) and the Medicare Conditions of Participation. Patients, in some settings are not given that option, but rather through coercion, fraud, neglect or more subtle manipulations are losing their protected health care rights.

The Problem

Nursing home chains have discovered "**hospice**" and the financial benefits it brings to their owners and shareholders. National hospice chains have discovered a rich source of referrals and revenues and have implemented plans to "milk" that resource through "**exclusive**" provider agreements that violate "patient choice." While seeking to "*focus on a patient-centered, outcome-oriented process that promotes patient care foremost rather than penalizing unproductive providers*" please don't underestimate the impact on human behavior of having to report quarterly results to market analysts. CMS still needs to utilize the "carrot and the stick" method to achieve its lofty goals.

These nursing home chains inherently can "influence" patients when they are most vulnerable -- at the point in their illness or when there is little or no resistance to a persuasive healthcare worker. Some patients may even be fearful of asserting their rights to choose a hospice provider (if they even know that they have that right!) for fear of retribution by the nursing home personnel.

Why is this an issue? In proposed 418.112, clarifying the relationship between nursing facilities and hospices there is the goal of ensuring "*that the resident meets all the same Medicare eligibility requirements as a patient who resides in his or her home..*" CMS pointed out in "**RESIDENTS RESIDING IN A FACILITY**" (page 30858 of the Federal Register) that the OIG's office has been very active in the "contractual arrangements between hospices and nursing homes." It appears that there is another initiative underway to deal with obligations regarding residents in LTC facilities receiving hospice services but we submit, additional strengthening of the Hospice COP needs to be included in these proposed rules.

Assured Home Health, Hospice, Home Care and Medical Staffing

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National nursing home chains who own their own hospice agencies, have developed exclusive relationships with their own captive agencies and so patients no longer have a "choice" of their Medicare hospice provider. This enables the nursing home chain to:

- Limit the oversight. There will be no "arms length" relationship to protect patients. One provider might be more inclined to cover for the other. If CMS only relies on Qui Tam reporting opportunities, the abuses will grow. If a nurse working for the nursing home division wants to run some errands and the hospice nurse who works for the same organization is available to cover for him/her, who will report it? Would this be viewed as a "gift" in order to secure referrals? How will CMS ever hear about it? Over the years, due to our agencies presence in several nursing homes, we reported several incidents of abuse by nursing home personnel and cooperated with the survey team to help them sanction those homes and personnel. We were another level of oversight and visa-versa. How will that happen when all the incentives are aligned against reporting violations? Will people report their friends, their fellow employees, their bowling team members? What if there is a problem patient who has no family, which is the typical nursing home patient, and the care is suspect, who will report it to the authorities? The employees of the same company who may have stock options in the parent organization? That didn't work at Enron, WorldCom and Tyco very well.
- The statement, *"It is not reasonable to expect the hospice to delegate any of its standard hospice core services to the nursing or residential facility staff"* sounds like someone at CMS still believes in the "tooth fairy!" Criminals don't do what is "reasonable." With no oversight because the nursing home has an "exclusive" relationship with its own company's hospice division, abuses will be guaranteed to make the news stories in the years ahead. And again, we will all gawk and shake our heads because we knew it was destined to happen.
- We attended a certificate of need hearing in our state recently and listened to a nurse who was the director of a local outlet of a national nursing home chain that was applying for a CON for hospice in the same area tell the audience, "I will not let my patients be taken care of by anyone other than my staff. That is why I want our own hospice agency." For emphasis, she stood and pointed her finger at the audience in a reproachful manner as she spoke. Does CMS think for one minute that this is an isolated response? While an argument could be made that she was simply passionate about the care they gave at her institution, she forgot one thing,

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IT IS NOT HER CHOICE, IT IS THE PATIENT'S! *It is not her decision. It is the patient's. And who anointed her as the sole judge of the "quality" care that SHE allegedly gives?* By not stopping this dangerous trend in its tracks, CMS is dooming itself and the OIG to continued "chasing of the abusers," always one step behind. The sad part is that these patients are the last ones who should be abused. They will take their abuse to the grave and the very feature of hospice, its palliative, dignified care and compassion will be only a statement on a wall, not a practice protocol for the patient.

- National hospice chains have also developed a highly trained, professional sales force to get nursing homes to sign exclusive relationships with them with promises such as by giving the hospice access to **all** the patients, the hospice provider will automatically enroll more residents in hospice and when the census reaches 10 patients, the facility will have a full time hospice nurse on premises. This again helps the facility if they are short of staff. How will CMS or the OIG ever know that this is going on? Oh, I forgot, Qui Tam. Has CMS ever seen their sales manuals? Has the OIG? There is another way.

The Solution

How does CMS enforce the law against this kind of subtle but exceedingly effective manipulation? We believe the following considerations are appropriate:

- While we agree with CMS' stated goal of improving outcomes and patient care, that will be a futile exercise if the trend of "steering patients" continues. A recent Harris Interactive poll showed that only 1%-2% of consumers changed their decisions when presented with information on quality. How many patients are going to even fathom what CMS comes up with to validate quality while they are dealing with the most traumatic event of their lives? They will never hear it or see it. They will only be told, "Here is the hospice nurse."
- CMS would be better served if it followed a model similar to other government agencies protective and proactive models. **That includes properly trained surveyors who can act on short notice to respond to an alleged violation, as they do for a patient safety violation.** It includes working with affected agencies to identify violations and violators. It

Assured Home Health, Hospice, Home Care and Medical Staffing

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includes working with patients to help CMS identify violators.

- **Finally, there have to be teeth to the law.** Unless a hospice or nursing home is sanctioned and fined significantly, the practice of “steering” will continue and probably increase since publicly traded nursing home chains and hospice agencies have discovered the significant financial benefit of a symbiotic relationship between the two. If there is no punishment, there will be no change in behavior.

Specific Recommendations

I. Restriction on National Hospice Chains and National Nursing Homes:

We propose that CMS establish rules that restrict any “exclusive” relationships with nursing homes and hospices. Medicare Certified hospices should not be allowed to enter into exclusive relationships. Separately, nursing homes should be mandated to offer their residents in the Medicare Program a choice of hospice provider and should be made to give their residents a list of the Medicare Certified hospice agencies that serve the area, much like hospitals are required to do with home health agencies.

II. Additional Steps to Assure Compliance:

Nursing homes should be mandated to require that every employee be in serviced on the law as it relates to “patient steering.” Each employee should sign a statement, similar to what is required now in sexual harassment policy documents, that they understand the law and recognize that if they “steer” a patient to the nursing homes hospice agency or to one agency, which has an exclusive contract with the nursing home, they could be subject to disciplinary action up to and including termination. Finally, each employee involved in the process should know that they are eligible for a cash award if they report corporate personnel to the OIG, who pressured them to violate patient’s rights for the benefit of the nursing home’s or the hospice’s financial standing. These steps will go a long way towards assuring compliance through self-awareness at all levels.

Assured Home Health, Hospice, Home Care and Medical Staffing

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Conclusion

CMS has the duty to protect patient's rights and to ensure the fairness and strength of the Medicare system. In a free enterprise system, hospices should have equal ability to serve patients using the traditional methods of education, community service, quality outcomes and community outreach. None of that is effective if a nursing home's employees "persuade" a patient to use the facilities captive hospice agency when they are most vulnerable. What good is improved quality if there is no access because of "patient steering?"

Enhancing the provisions of the Medicare Conditions of Participation Proposed Rules to protect a patient's "right to choose" their own Medicare provider, will ensure the integrity of the Medicare Program and the achievement of the four measures for the outcome domains of **self-determination**, comfort, safety and effective grieving.

Sincerely,



Richard D. Block
President

Cc: R.J. Ruff, Jr., FAAMA, CHE-CMS Regional Administrator
Anne Keopsell, Executive Director, WSHPCO
Mark Rake-Marona, Western Regional Representative NHPCO

RDB: nbc

Assured Home Health, Hospice, Home Care and Medical Staffing



June 30, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-3844-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: 2005 Proposed Medicare COPs for Hospice Programs

Dear Staff of CMS:

Both Sylvia Marcantel, RN and I attended NHPCO's Train the Trainer Session in Baltimore on June 9-10, 2005, where CMS presented in detail the new proposed Medicare COPs for Hospice Programs. We were very pleased with CMS's preparation and presentation of the training to aid us in reviewing the information with hospices in our states. We provided this information to all members of the Louisiana and Mississippi Hospice & Palliative Care Organization (LMHPCO) in both states. Members were given time to review the information before we held a conference call to discuss the proposed COPs. Members were then given another week to provide comment back to Sylvia and I, so we could formulate our member's responses into a single document to provide CMS our unified response. We feel comfortable that this document represents our member's consensus. The following represent our comments for the proposed Hospice COPs:

Preamble

- 1) Throughout the preamble the term "hospice industry" is used. We believe the correct terminology should be "hospice associations" in the context used, because the information cited has been provided by NHPCO. While NHPCO does represent a large amount of hospices across the country, it does not represent the entire "hospice industry".
- 2) On page 30842 of the federal register, discussion centers on "outcome-based measures". CMS cites the work of a Task Force that was convened by the National Hospice Work Group (NHWG) and NHPCO in 1999. We believe this work was relevant and necessary to advance the outcome-based studies hospice should be considering. However, there is a significant disconnect between the topics of these studies and the topics that CMS is suggesting that hospice track in 418.58. The Task Force created four measures for the outcome domains, including self-

determination, comfort, safety, and effective grieving. While all of these are certainly important outcomes, they do not all meet the requirements specified in 418.58(c), which specifies that “performance improvement activities must focus on high risk, high volume, or problem-prone areas.” We understand the intent of what CMS is trying to indicate, but we believe both the preamble and section 418.58 needs some clarification. We recommend one Standard be created for Quality Assurance and one Standard be created for Performance Improvement Activities. The language in the preamble is really directed towards the Quality Assurance Standard, while language in 418.58(c) is directed towards the Performance Improvement Activities. Much of the confusion related to outcome-based measures during our meeting in Baltimore can be attributed to not talking about these two topics as separate Standards. Quality Assurance ensures high quality of care is being provided. Performance Improvement Activities are specifically initiated to fix problematic areas.

3) On page 30850 of the federal register, CMS describes how Medicare makes a distinction between providing services directly, as opposed to providing services under arrangement. CMS states the most common way is to utilize employees. Then Medicare cites a common law definition. CMS should clarify if its intent in citing the common law definition was to promote its use in determining whether or not an individual is considered an employee of a hospice.

4) On page 30850 of the federal register, CMS discusses the requirement of licensed professionals, such as PT, OT, and ST, participating in coordinating all aspects of care, including updating the IDT comprehensive assessment, developing and evaluating plans of care, participating in patient and family counseling, participating in the quality assessment and performance improvement plan, and participating in inservice training. First, CMS should clarify this is only appropriate when these licensed professionals are treating specific patients. Currently, the language implies licensed professionals would be involved in these activities for all patients. PT, OT, and ST are used infrequently in hospice, but are needed for some plans of care. They should not have to be involved in all activities. Second, we do not believe professionals, such as PT, OT, and ST, should be involved in the hospice quality assurance and performance improvement activities. These activities should be administered through the employees of the hospice.

5) Also on page 30850 of the federal register, CMS states that “contracted individuals would be required to actively participate in the coordination of care, including patient assessment and care planning, and in the primary hospice’s inservice training and quality assessment and performance improvement process. We have the same concern here that we had in #4 above. Please clarify that these contracted individuals would only participate in these activities for patient’s they were treating. We also do not believe contracted individuals should participate in the hospice’s quality assurance and performance improvement activities.

6) Spiritual counseling is an important part of hospice. On page 30851 of the federal register, CMS states, “If a patient and family do desire spiritual counseling, then a hospice would be expected to facilitate visits by local clergy, pastoral counselors, or others to the best of its ability.” We believe this lessens the importance of requiring these services. These services must be provided as part of the plan of care. Also, in this same paragraph, CMS using the term “desires”. We suggest changing this term to “goals”.

7) On page 30855 of the federal register, under section 418.104(e)(2), CMS is requiring the hospice to submit a copy of the patient's clinical record and discharge summary to the patient's attending physician, if the hospice patient revokes or if the hospice discharges the patient. We disagree with this requirement. This information can be provided to the attending physician, if he or she needs the information and requests it. Further, it is the patient's right to determine who should receive the information and when. We are concerned that a HIPPA violation would occur in this scenario, because the information is being provided without regard to need and without a direct request from the patient.

8) On page 30855 of the federal register, under section 418.104(e)(3), the term "patient's stay" is used. Since the vast majority of hospice care is not provided in a facility the hospice owns and operates, we suggest this be changed to "patient's service duration". "Patient's stay" is more appropriate for nursing facility or hospital COPs.

9) On page 30855 of the federal register, under section 418.104(f), Retrieval of clinical records, we would like to see some language that allows for cost recovery according to state law for the gathering and copying of records. The currently proposed language could imply that clinical records must be made available regardless of payment for gathering and copying services.

10) On page 30855 of the federal register, under section 418.106, CMS discusses the responsibility and accountability for maintaining controlled substances in the home. CMS indicates that primary responsibility rests with the hospice. We strongly disagree. The family takes responsibility for the controlled substances upon delivery to the home. Hospice provides intermittent care and in no way can protect the controlled substances 24 hours a day. Hospice should provide oversight and monitoring of the controlled substances, but hospice should absolutely not be primarily responsible for the controlled substances in the possession of the patient and/or family.

11) On page 30856 of the federal register, under section 418.108, we suggest CMS add "inpatient facility" after "...provided either in the hospice inpatient facility or in a participating Medicare or Medicaid facility."

12) On page 30856 of the federal register, under section 418.110, we suggest CMS add "whenever possible" at the end of the sentence, "We would require that each patient be kept comfortable, clean, well-groomed and protected from accident, injury, and infection, whenever possible." This is necessary, because hospice cannot not always prevent an accident or infection. By definition an accident is unexpected, and infections occur even when the best medical care is provided.

13) On page 30858 of the federal register, under section 418.112, we suggest CMS add "hospice" in this sentence, "Regardless of where the hospice patient resides, the responsibility for developing and implementing an appropriate hospice plan of care rests with the hospice."

14) On page 30858 of the federal register, under section 418.122(e), bullet (1), CMS states that "Written consent and documentation of the patient or the patient's representative that hospice services were desired" is required. This should not be part of the overall contract between a hospice and a facility. This is a consent from a patient to receive hospice services and it belongs in another section of the COPs. One agreement needs to govern the way the hospice and facility will work with each other for all patients, so the agreement should not identify specific patients.

15) On page 30860 of the federal register, under section 418.114, related to social workers, CMS states, "Later, the social worker's goal is to help family members during the bereavement process through in-depth counseling." While this is true sometimes, a hospice chaplain or bereavement counselor often provides this service. The proposed language seems to limit these services to a social worker. We do not believe this is appropriate.

418.3 Definitions

1) Clinical Note – The use of "or" should be used in this definition. The way it is written implies that all of the elements listed must be present in order for a document to be considered a "Clinical Note".

2) Drug Restraint – The use of the term "standard" is confusing, because most drugs that are administered to restrain a patient would be considered standard treatment for a patient's medical or psychiatric condition that would require restraint.

3) Employee – We do not believe that a Volunteer should be considered an Employee. Volunteers should have a separate definition. Legally, hospice does not have the same control of or obligations to Volunteers that it has to Employees. This definition could be problematic for hospice in the legal system.

4) Palliative Care – We question the use of the term "intellectual" and the phrase "to facilitate ... access to information". These seem to be beyond the scope of Palliative Care.

5) Satellite Location – Can CMS provide a general definition to limit the distance a Satellite Location can be located from the main Provider # site? Some regional CMS memos have indicated that a Satellite location must be within the same "catchment" area as the main Provider # site. This should be specified in the COPs to give clear guidance to hospices.

Subpart C Patient Care

418.52(a) Standard: Notice of Rights

1) Regarding "in a language and manner that the patient understands during the initial evaluation visit in advance of furnishing care." We suggest you include language to cover "to the extent possible", since providing written materials may limit access to care. We also suggest you include language to meet this standard for minority languages that are most common in a given area, since it is impossible to cover all languages and dialects.

3) We believe the provision of all drug policy information upon admission is too much information for the patient and family to absorb immediately upon admission. We suggest changing to within the timeframe of the comprehensive assessment, which we believe should be within 7 days of admission and also upon the addition of new orders for additional controlled substances. Hospice should be able to provide information to the patient and family in a handbook upon admission, and then allow the patient and family to review. The hospice would then explain the policies in detail and answer any questions within 7 days of the admission to the patient and/or legal representative.

4) Please clarify the term "demonstrated" as meaning a signature of the patient or legal representative.

418.52(b) Standard: Exercise of rights and respect for property and person

1) We believe (iii) should include language to include the right to refuse treatment such as, "The patient has the right to refuse treatment or to refuse to participate in experimental research." We also suggest adding (v) and including, "The patient has the right to formulate an advance directive."

3) We suggest adding "and practice." to the end of the sentence.

4) We suggest using the Home Health language from the HHA COPs, as this language is more appropriate for hospice than the language from the Nursing Facility COPs. We also suggest removing any language that would require a report of "alleged violations" to the State survey agency within 5 working days. This is language specific to Nursing Facilities.

418.52(e) Standard: Patient Liability

CMS has requested comment related to notification of expected payment from the patient and determining patient's liability related to nursing facility Medicaid Room & Board payments.

Hospices notify, to the extent possible, the patient or legal representative of any expected charges prior to admission. For standard Medicare/Medicaid hospice services this is not necessary, as no charges are passed on to the patient. There are often times we do not have the patient co-pay, co-insurance, or deductible information from commercial payors prior to admission. Requiring this information prior to admission can significantly delay the admission, thus affecting quality patient care for patient's in immediate need of care. We again believe that this kind of information should be provided to the patient and family within the 7 day timeframe of the comprehensive assessment. This allows the hospice to provide the immediate care needed and gives the hospice time to communicate with the commercial payor to determine any patient responsibility. Advance Beneficiary Notices (ABN) or notices of non-coverage are sometimes used to communicate this information.

Hospices often have difficulty obtaining patient's liability information related to nursing facility Medicaid Room & Board. Since the current pass-through law is legislated at the federal level for dually eligible Medicare and Medicaid beneficiaries, we would like to see some language in both the Hospice and Nursing Facility COPs that helps facilitate the coordination of this information between the Hospice, Nursing Facility, and Medicaid.

418.54(a) Standard: Initial assessment.

We suggest including the following language, "(unless ordered otherwise by the physician or as requested by the family)".

418.54(b) Standard: Time frame for completion of the comprehensive assessment.

Please clarify that "in consultation" does not mean the attending physician must be present in person. We believe the 4 day timeframe is too short and strongly suggest modifying to 7 day timeframe. Many times families request a later visit or deny the chaplain or social worker visits the first week while more immediate pain issues are addressed. It has been suggested that other IDT members could complete the initial assessment, such as a social worker. We believe that an RN should complete the initial assessment, since patients often have medical issues requiring immediate attention.

418.54(c) Standard: Content of the comprehensive assessment.

In (ii) Drug therapy we suggest adding a bullet that requires all drugs in the medication profile be listed and to designate which drugs hospice will be responsible for. We also suggest adding language of "drugs that are reasonable and necessary for the palliation or management of the terminal illness." Too often patients and families desire drugs with are proven not to be effective

in the terminal phase of an illness and only benefit in the early or mid stages. Usually these are cost prohibitive and have no benefit.

418.54(d) Standard: Update of the comprehensive assessment.

Some parties have commented that the comprehensive assessment should be updated every 15 days to tie into certification periods. We disagree with this suggestion. We believe the existing 14 day review is appropriate. We also do not believe it is necessary to have a timeframe specified to review the comprehensive assessment prior to recertification, since the review of the comprehensive assessment will likely take place on a different day than the recertification. The existing requirement allows hospices to review the comprehensive assessment as frequently as is necessary, which provides flexibility to provide the appropriate care to the patient and family.

418.54(e) Standard: Patient outcome measures.

We do not believe "patient outcome measures" are too burdensome for hospices. However, we would like the procedure to be clearly defined as it pertains to hospice, such as what is an adverse patient event? We do not want a certain number of quality improvement projects that have to be done each year, but rather issues that are discovered during normal program auditing should be documented on how they were improved to meet standards.

Examples of outcomes indicators are:

- Pain management (6 indicators relative to assessment and reassessment)
- Fall risk and prevention
- Adverse drug reactions
- Medication reconciliation
- Life closure
- Device-related urinary tract infection
- Management of documentation
- National Patient Safety Goals implementation
- Wound management

We do not want these prescribed in the regulations, but a list like this could be provided as an example. Some guidance should be given to allow new programs a foundation to start from; however, hospices should select their own measures depending on the risk factors determined in each program.

418.56(a) Standard: Approach to service delivery.

- (1) Please add a provision to allow the hospice medical director to be the patient's attending physician. We believe that allowing the hospice to designate a qualified hospice professional that is a member of the interdisciplinary group is appropriate to coordinate the care of each patient and family. This person should not have to be an RN; however, we do believe the selection should be limited to an RN or social worker, since both have medical training and college education. Other disciplines may have more limited training and education and may not be best suited to coordinate this care. In bullet (iv) the IDT role was narrowed from the original COPs. We suggest, "a counselor, including pastoral, clergy, spiritual, or other counselor."
- (2) We disagree with the proposed language. One IDT does not establish governing policies of the day-to-day care. An administrative team establishes policies and procedures and oversees the day-to-day provision of hospice care and services.

418.56(c) Standard: Content of the plan of care.

In (2) we would like a provision added to allow flexibility to increase the frequency upward to address changing needs, such as 2 X week and prn. In (6) we do not believe "agreement" is the most appropriate word to use. Patients and families may not agree with the entire plan of care,

but need to be knowledgeable of what is included in the plan. They may want more aggressive treatment than hospice was designed for or is covered by the Hospice Medicare Benefit. Also, the family may not be in agreement, but the patient is. We suggest using “knowledgeable” instead.

418.58(c) Standard: Program Activities.

In (2) please clarify “adverse patient event”. We do not want a certain number of quality improvement projects that have to be done each year, but rather issues that are discovered during normal program auditing should be documented on how they were improved to meet standards.

418.58(d) Standard: Performance improvement projects.

We do not want a certain number of quality improvement projects that have to be done each year but rather issues that are discovered during normal program auditing documentation on how they were improved to meet standards.

418.58(e) Standard: Executive responsibilities.

In order to fulfill the Governing Body’s responsibility for the quality of care and services provided, it must receive performance information regarding the results of outcome measurements, so that it can provide input and allocate resources for identified improvements.

418.64 Core services

We believe contracting for staff for continuous care should be allowed. Most hospices are small and cannot afford to hire full time continuous care staff, nor is it feasible to even find staff that will be able to stay continuously with a patient in the middle of the night at a moments notice. Disallowing contracting of staff basically eliminates the possibility of providing continuous care when a patient desperately needs it. The consequence of this is likely an ER admission to a hospital, which is significantly more expensive and is not the best course of treatment for the patient and family. CMS should definitely consider these issues before disallowing contract staff for continuous care. Disallowing this option is not in the best interests of the patient and it is more costly to the Medicare system.

418.64(d) Standard: Counseling services.

Hospice provides counseling services to patients and families in their homes and in a nursing home setting in the same manner. No denigration of services occurs. Bereavement services are provided through memorial services and private or group sessions for staff or other residents in nursing facilities. Unfortunately, not all nursing facilities take advantage of these services, but neither do all families.

418.72 Condition of participation: Physical therapy, occupational therapy, and speech-language pathology.

We believe the dietitian should be moved to the list of non-core services. The dietitian serves more like a therapy provider than a counselor.

418.76 Condition of participation: Home health aide and homemaker services.

We believe “home health” aide should be changed to “hospice” aide. Most hospices do not provide home health.

418.76(g) Standard: Home health aide assignments and duties.

In (2)(i) an aide should not need an MD or nurse practitioner order to perform duties. The RN Case Manager assigns aides duties, and includes these duties in the plan of care, which a

physician signs. Home Health needs orders for these services, because Home Health is administered in a very different fashion and its staff and goals are also very different. It needs to be assumed that all services are available for the hospice patient, and the RN may assign as needed. This information is documented in the plan of care, if the IDT needs to coordinate this information. Hospices need to be able to defer to state law (such as the nurse practice act), especially with regards to medications. Most allow delegation to the aide or unlicensed staff the task of assisting the patient to take their own medications, as long a judgment is not required. They can physically move the medication to the mouth and give the patient water or liquid to aid in swallowing.

418.76(h) Standard: Supervision of home health aides.

COPs should specify that supervisory visits assessing the aide services may be conducted when the client is admitted, recertified or during a prn visit. We agree that the RN should make an onsite visit to the patient's home no less frequently than every 14 days to assess the aide's services. We absolutely disagree that an RN should be onsite with the aide no less frequently than 28 days. We believe onsite visits should be made at least every 90 days. This should not be for every patient. The intent of this standard is to assess the aide's competency. This can be accomplished sufficiently by having each aide visit one of their patients, while an RN assesses the aide's competency.

418.76(i) Standard: Individuals furnishing Medicaid personal care aide-only services under a Medicaid personal care benefit.

It is very important that CMS add language that it is not a duplication of services to have a waiver aide-only service and the Medicare/Medicaid Hospice Benefit at the same time. In Louisiana the waiver is denied, if hospice services have been elected. This most often prevents the patient from accessing the Hospice Medicare Benefit at the time they need it the most. The waiver aide does not provide clinical care. The waiver aide is simply a sitter. Terminally ill patients must have access to professional clinical care at the end of their lives.

418.78(e) Standard: Level of activity.

A major point of revising these regulations is to make the regulations less prescriptive and "to focus on a patient-centered, outcome-oriented process that promotes patient care foremost", according to the preamble associated with these revisions. We believe that setting a 5% volunteer hour minimum is simply a prescriptive method to ensure volunteer utilization that has absolutely nothing to do with providing quality patient care. The 5% target is an arbitrary percentage that has no basis to ensure quality patient care. It is interesting that our existing regulations prescribe this minimum percentage to require volunteers, yet require no minimum number of visits for patient care staff. Ensuring a minimum number of patient visits would have had a significantly larger affect upon quality patient care that designating a specific number of volunteer hours. We would like this prescriptive 5% minimum removed from the regulations, since it is not a statutory requirement. In order to ensure volunteer continuity, the volunteer program should document recruiting, educating, and retention of volunteers and the process of assigning appropriate volunteers to patients with needs that can be met by volunteers.

Subpart D Organizational Environment

418.100(a) Standard: Serving the hospice patient and family.

Substitute "promote" in place of "ensure", since you cannot ensure patient/family experiences. Also, in (2) substitute "goals" in place of "desires", since desires may actually be significantly

more than what is needed to accomplish goals and interventions of a plan of care. Finally, we suggest adding (3) "When the patient and family are not in agreement with the election of hospice care and/or the plan of care, the hospice will honor the patient's needs and goals."

Section 418.100(e) Standard: Professional management responsibility.

Requiring hospice agencies to supervise the staff and services provided pursuant to independent contracts probably will result in the IRS concluding the entity or person providing the service is an employee of the agency and not an independent contractor. One of the critical factors distinguishing employees from independent contractors is whether the employer significantly controls and supervises the work. The hospice should not be required to supervise staff and services for all arranged services. Further, in section (e)(2) of this Section, personnel of arranged services are not likely to have the same qualifications as hospice employees. Hospice employees perform their jobs routinely every day, which provides them certain skills that outside contracted personnel would have difficulty achieving without the same experience. This requirement should be changed to require the hospice to ensure that arranged services are provided by qualified personnel.

Section 418.100(f) Standard: Hospice satellite locations.

The preamble states that CMS is "accepting comment on applying the Medicare Appeals Procedures that affect participation in the Medicare program." We are not sure how this relates to the approval of hospice satellite locations. We would recommend continuing to use the CMS Form 855A to establish new satellite locations with CMS. Please elaborate on how the Medicare Appeals Procedures affects hospice satellite locations.

418.102 Condition of participation: Medical Director

The proposed addition should be changed to "When the medical director is not available, a physician designated by the medical director or the hospice assumes the same responsibilities and obligations as the medical director. The medical director or physician designee coordinate with other physicians and health care professionals to ensure that each patient experiences medical care that reflects hospice policy." Also, please specify that a hospice may contract with an entity (such as a hospital) to allow a physician to serve as a hospice medical director. Many hospitals control physician's time, since the hospitals pay physicians a salary. Consequently, many contracts have to be made with the hospitals directly to allow the physicians to devote some of their time to medical director activities.

418.102(c) Standard: Coordination of medical care.

The Medical Director should be a "participant" in the QAPI Committee/Program, but should not be responsible for directing the hospice QAPI Committee/Program. The hospice Governing Body should be responsible for the QAPI Committee/Program and the hospice Governing Body should be able to designate a member of the hospice staff to direct the QAPI Committee/Program.

418.104 Condition of participation: Clinical records

Advantages of using an EHR:

1. Access from any computer anywhere in the world at any time of the day.
2. Easily portable.
3. Clean copy that is legible, if notes are typed vs. scanned.

Disadvantages of using an EHR:

1. Must have very computer literate clinical staff, which is often unavailable in today's environment.
2. Must carry laptop from house to house. This causes many issues, including the appearance of a "cold machine" between the clinical staff and the patient/family, breakage caused by dropping laptops (occurs often), theft out of cars (laptops are targets for thieves), potential cross contamination between households (laptops are not sterile medical instruments, nor are they disposable items that are only used in one household).
3. Significantly increased costs of infrastructure, software, maintenance, training, data entry staff, etc.
4. If laptops are not used, and handwritten notes are used instead and then entered at the office to become part of the EHR, several issues arise: 1) gaps in time between handwritten note and entry into EHR puts patients at risk, if information is not immediately transcribed. Under any circumstance, there would always be a gap in time which puts the patient at risk. 2) double entry / double time to complete a medical record caused by handwriting the note and then entering the note in the computer. 3) transcription errors are possible by taking a handwritten note and transcribing into the EHR. Transcription errors associated with medications could especially put a patient at risk.
5. Increased time devoted to EHR, instead of patient care. EHRs tend to work well in facilities such as hospitals, nursing facilities, or doctor's offices. This is due to the nature of the care provided and the location. For example, hospitals and doctor's offices bill hundreds, if not thousands of codes for different procedures. EHRs have been created to help these entities bill appropriately and efficiently. Hospice only uses 4 billing codes, and 1 code is used 90%+ of the time. Consequently, hospice gains no efficiency by implementing an EHR system. Hospitals, nursing facilities, and doctor's offices are all physical locations where an EHR system can be placed for easy access. The system is always on and ready to be used. Since hospice provides care in hundreds of homes across a given community, the only logical way to implement an EHR is to use a laptop system for portability. These systems would be turned on and off all day long as they are transported from one home to the next. This process of booting a machine and shutting it down takes time, and forces a clinical staff member to spend more time working with the computer than the patient/family. A clinical note can be written by the time a laptop is turned on, so this is definitely an added burden.
6. Unless hospices provide laptops to every staff member and volunteer (this is not practical), hospices would still have handwritten notes from certain disciplines that would have to be entered by a new data entry employee in order to have a complete EHR. Due to this practicality issue, we have seen some providers in our states try to implement an EHR by only providing laptops to nurses. All other disciplines retained using the process of handwritten clinical notes. This system is not a true EHR, because more than half of the IDT is not included in the EHR. However, this is as far as these providers were willing to go to implement an EHR due to the practicality of providing laptops to every staff member and volunteer.
7. One of our largest hospice providers that serves multiple states across the country abandoned a trial run of implementing an EHR due to the same problems mentioned above. This is an organization that has the resources and infrastructure to take on a task like this, but reported that due to the model of providing hospice services throughout the community, the cost-prohibitive nature of providing laptops to all staff and volunteers, the extensive training, and the very long learning curve, they decided to go back to handwritten clinical notes. It was just too difficult to fully implement outside of a facility, and the hospice failed to recognize any positive patient

outcomes. In fact time devoted to patient care was decreased as a result of the implementation of the EHR.

Barriers/Issues with electronic medical records:

1. Learning curve of computer program is long.
2. Staff available is often poorly trained in use of computers.
3. Decrease in number of hours spent providing patient care in order to utilize the EHR system.
4. Security of computer devices.
5. Maintenance of devices and system; troubleshooting on a daily basis.
6. Increase in staff numbers.
7. Cost.

418.104(b) Standard: Authentication

Hospice is simply too broad to implement this newly proposed regulation. Too many physicians and nursing facility staff are included in our coordination of care to implement this across all persons connected to a clinical record. We suggest removing this requirement, as this is onerous and does not provide for better patient outcomes.

418.106(b) Standard: Controlled drugs in the patient's home

We believe that education of the "potential dangers" of controlled substances must be taught for patient, family, and staff safety. However, "potential dangers" is misleading and we would like "side-effects" substituted in its place.

418.106(c) Standard: Use and maintenance of equipment and supplies.

This Section should be rewritten to specify that when DME is provided by a contracted vendor, the vendor assumes the responsibility to ensure internal or manufacturer policies exist for repair and routine maintenance of equipment. The hospice should be required to verify these policies are in place with the vendor the hospice chooses.

418.108 Condition of participation: Short-term inpatient care.

We suggest that you include a description of short-term inpatient care and when it can be utilized. General Inpatient care is designed to be provided intermittently and can be used to 1) to provide pain and symptom management that cannot be provided in the patient's home either due to the staff required or the equipment necessary to provide the care, 2) ensure appropriate care due to the inability of the hospice and or the patient's caregivers to provide services in a safe and effective manner in the home, or 3) ensure continuity of care in the event of a psychosocial or family problem. Inpatient Respite care is limited to a five day duration and is used to give the family/caregiver a break during the care of the patient.

418.108(a) Standard: Inpatient care for symptom management and pain control.

We agree with removing the 24 hour nursing coverage requirement for Inpatient Respite care. However, we believe the 24 hour nursing coverage requirement should remain in effect for General Inpatient care.

418.112(d) Standard: Medical Director

Medical directors of hospices and nursing facilities should not have to be the primary designees coordinating care for a hospice patient. Instead, the IDT should be allowed to designate a team member to coordinate care. Also, we do not agree that it is necessary for the hospice medical

director to communicate with the SNF/NF medical director, the patient's attending physician, and other physicians in the provision of care for the terminal condition to ensure quality care for the patient and family. The hospice medical director needs to be able to provide services with some autonomy to make decisions for the patient and family. The attending physician can request to receive communication related to updates to the patient and family care, but the hospice medical director is ultimately responsible for this care. Some attending physicians want to be more involved in care planning than others, but this is an individual preference that varies by physician. Most attending physicians develop a relationship with the hospice medical director and become comfortable with the medical director's assumption of the responsibility to participate in the IDT care planning process.

418.112(f) Standard: Hospice plan of care.

We would prefer the 14 day interval to review the plan of care to remain in place. Some providers have suggested maybe moving to a 15 day interval to tie in with recertification periods. However, leaving the standard as 14 days allows the IDT to have regular meetings on specific days of the week (i.e. every other Tuesday). This logistically works well with hospice medical directors too, because they can block out their clinic days on Tuesdays, for example. Recertifications that come due can be anticipated and can be reviewed at the IDT meeting immediately preceding the recertification.

418.112(i) Standard: Orientation and training of staff.

This proposed Section would inundate facilities with an overflow of inservices that likely couldn't be accommodated in the facilities schedules. We suggest modifying the language to state, "Hospice staff must assure orientation of facility staff."

418.114 Condition of participation: Personnel qualifications for licensed professionals.

This Section seems to indicate that a non-degreed social worker can be hired to fulfill the duties of a hospice social worker, because they are "licensed" by the State. This is a lower qualification level than is currently in place. We strongly believe that a degreed social worker remain the standard for hospice care. Section 418.114(c)(7) specifies a baccalaureate degree requirement, but only when no State licensing requirements exist. In a state where State licensing requirements exist, a non-degreed social worker could fulfill the duties of a hospice social worker under the proposed condition of participation. This needs to be modified to correct this problem.

418.114(c) Personnel qualifications when no State licensing, certification or registration requirements exist.

CMS has requested comment on (7) social worker related to the possibility of requiring an MSW to fulfill the hospice social worker duties. The BSW curriculum is obviously not as rigorous as the curriculum for an MSW. We believe an MSW is often better prepared to fill the role of a hospice social worker, but MSWs are often difficult to find in many states, especially rural states. We would propose that the MSW requirement be imposed, but a waiver should be given to hospices that show cause why they cannot hire an MSW. CMS should keep in mind that many hospices will not be able to hire MSWs due to the location of the hospices and local availability of MSWs. CMS should also consider that while one MSW may exist in a small rural area, the hospice may not be able to afford the MSW due to price competition for the limited supply of MSWs in that area. Also, if an MSW requirement is imposed, existing hospice social workers must be grandfathered in to allow them to continue practicing as hospice social workers. We

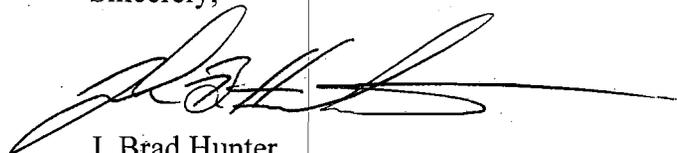
believe one year of experience as a social worker is appropriate before becoming a hospice social worker. It is not necessary to have this one year of experience in a health care setting. This would significantly limit the pool of new social workers entering hospice, as they are more likely to remain in the health care setting they were originally hired in.

418.114(d) Standard: Criminal background checks.

States already require specific criminal background checks that vary by state. We would suggest removing this Section from the proposed conditions of participation. If the condition remains, there must be some guidance as to what law violations prevent staff from being hired and what response or action is to be taken when a criminal background check reveals violations of the law.

Thank you for the opportunity to comment on the proposed hospice COPs. If you have any questions or comments related to this response, please contact me at your convenience at (205) 970-8888, ext.102 or via email at brad@chahospice.com.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Brad Hunter', with a long horizontal flourish extending to the right.

J. Brad Hunter
President

To: Department of Health and Human Services

Re: Medicare requirements for Masters in Social Work (MSW): file code CMS-3844-P

Date: June 29, 2005

I'm responding to your request for comments concerning the Medicare requirement for MSWs in the hospice setting. The Federal Register article cited several reasons for changing this requirement. Additional reasons include:

- 1) In order to receive a MSW, students are required to have about two years of clinical internship in different settings where they are supervised by another MSW. Clinical experience enables the student to gain real life experience, which can't be duplicated in a classroom situation. People with a bachelor's degree or Masters in Counseling don't receive these intense clinical experiences.
- 2) Most hospitals require social workers to have a MSW as cited in Social Work Today, March 24, 2003. MSWs are trained to ask questions, which encompass the holistic approach. Hospice social workers tend to follow people longer than in a hospital setting. We interact with clients and their family and friends in a different way, have a better understanding of community resources, and since we work primarily with people in their homes don't have the immediate back up of co-workers in difficult situations. Thus hospice social workers should have the minimum requirements for hospital social workers.
- 3) Incorporating the requirement of one-year experience in a medical setting enables the MSW to better understand the medical terminology and abbreviations often used in documentation. However, due to the shortage of MSWs, this could be more of a recommendation than a requirement.
- 4) Rural areas do present a challenge in meeting the MSW standard. The HHS department's suggestion of having assistant social workers supervised by an MSW is a viable one.

Social workers are called in to deal with difficult and complicated situations, which often occur when people are in emotional and/or psychological pain. Without the necessary training and expertise, well-intentioned people can do more harm. Raising the standard of care for hospice social workers will better insure that patients and their families and friends will receive the necessary support and resources at a very vulnerable time in their lives.

Thank you for soliciting comments on this very important issue.

Respectively,


Marla Karow, MSW
Samaritan Evergreen Hospice
(541) 812-4659
mkarow@samhealth.org



HOME HEALTH & HOSPICE
COLUMBUS COMMUNITY HOSPITAL

June 22, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3844-P
P.O. Box 8010
Baltimore, MD 21244-8010

To whom it may concern,

I attended an information session on June 20th, where I had the opportunity to be educated on the 2005 Proposed Medicare Conditions of Participation for Hospice Programs. I feel that strongly that I need to comment on the proposed issues of Social Work qualifications (418.114 (7))

I have worked as a Medical Social Worker, in the area of Hospice for the last eight years, with a bachelor's degree. Up until the last couple of years I would have defended the issue that a BSW was perfectly capable to serve in this capacity. I have been in the process of pursuing my Master's Degree in Social Work for the last two years; I have found that I do not believe that I have done my past clients justice. I feel that I have had the skills to listen and do case management, but the assessment and counseling skills were not as effective as needed. With many Hospices using the Social Worker and Counselor as a dual role I now believe that it will be imperative to have a Master's level person in that position. When there is the possibility of having both the BSW and a professional counselor, the skills of the Social Worker is used to determine if the counselor is needed.

With a BSW, you are taught the basics in community resources, case management, advocacy, and, limited assessment skills. As a MSW, you are intensively educated on assessment of individuals and family functioning, and how to counsel them. This is very important when working with Hospice patients.

A good example of this would be in the area of grief versus depression. So many times we see in IDG's a patient being put on an anti-depressant because of depression. Since taken masters classes I have been able to do some assessments and determine that it was grief, and grief cannot be treated with medication. Treating grief with medication can lead to unnecessary medication reactions, and cost. Where as the treatment for grief is communication, and counseling.

Coming from a smaller community I can see the impact that this could have on the smaller rural hospice organizations. But I firmly feel that a Master's level person should somehow be involved with each Hospice patient. Being in the position that I am in I can see both sides of this issue.

Please feel free to contact myself if any further input or comments are needed, (402) 562-4496

Sincerely,

Lisa Weber DeVoll, BSW, CSW



1549 Clairmont Road, Suite 103 • Decatur, GA 30033-4635 • Phone 404/320-1472
 Fax 404/320-0849 • Website: www.acpe.edu • Email: acpe@acpe.edu

9

**ASSOCIATION FOR
 CLINICAL
 PASTORAL
 EDUCATION, INC.**

Teresa E. Snorton, D.Min.
 Executive Director

Deryck Durston, M.Div, S.T.M.
 Associate Director

June 30, 2005

Centers for Medicare and Medicaid Services
 Department of Health and Human Services
 Attention: CMS-3844-P
 P. O. Box 8010
 Baltimore, MD 21244-8010

Dear CMS:

This is in response to the proposed rule to revise the existing conditions of participation that hospices must meet to participate in the Medicare and Medicaid programs. Specifically, we are supportive and appreciative of CMS's commitment to have requirements that focus on the care delivered to patients and their families by hospices, including attention to spiritual care.

The Association for Clinical Pastoral Education, Inc. is a professional association committed to advancing experience-based theological education for seminarians, clergy and lay persons of diverse cultures, ethnic groups and faith traditions. We establish standards, certify supervisors [faculty] and accredit programs and centers in varied settings. Clinical Pastoral Education (CPE) is the requisite training for board certification as a professional chaplain. ACPE programs promote the integration of personal history, faith tradition and the behavioral sciences in the practice of spiritual care. We have nearly 350 accredited programs and over 800 certified faculty nationwide. For further information about ACPE, Inc. please visit our website at www.acpe.edu, or contact our Executive Director, Rev. Dr. Teresa E. Snorton at 404-320-1472.

We would like to offer this response to the proposed rule:

PROPOSED 418.62: LICENSED PROFESSIONAL SERVICES

The proposed hospice rules contain specific standards for licensed professional services. We understand the rationale for basing these upon State standards for those in other healthcare professions, such as physicians, nurses, therapists, medical social workers, home health aides, etc. However, **professional spiritual care providers** are first extensively training and then board certified by national professional groups. We would encourage that the proposed rules include this requirement of training and board certification for those providing spiritual care and counseling in all hospice settings.

President
A. Arthur Schmidt, Jr., D.Min.
 St. Francis Hospital
 34515 9th Ave. S.
 Federal Way, WA 98003-6761
artschmidt@fhshealth.org

President-Elect
Joan E. Hemenway, D.Min.
 76 Grist Mill Cir.
 Guilford, CT 06437-1919
jhemen@att.net

Secretary
Jenny T. Lannom, M.Div.
 Presbyterian Healthcare Services
 P. O. Box 26666
 Albuquerque, NM 87125-6666
jlannom@phs.org

Treasurer
Paula J. Teague, D.Min.
 The John Hopkins Hospital
 600 N. Wolfe St.
 Baltimore, MD 21287-0005
pteague1@jhmi.edu

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ACPE, Inc. Response to CMS-3844-P

June 30, 2005

In addition to undergraduate and graduate theological degrees, a Board Certified chaplain must complete a minimum of 4 units (requiring 1600 hours of training) of Clinical Pastoral Education, which is nationally recognized clinical training in the provision of professional spiritual care. Clinical Pastoral Education is an outcomes-based educational program, recognized by the United States Department of Education. Our standards focus on the development of pastoral formation, pastoral competence and pastoral reflection.

Pastoral formation aids the professional spiritual care provider in self-awareness, values assessment, and use of consultation. Pastoral competence leads the student in skill development, i.e. pastoral care skills (listening, empathizing, conflict resolution, crises management) counseling, spiritual assessment, multidisciplinary teamwork, multicultural concepts of religion, spirituality and care, care to the grieving, leadership, management, positive use of power and authority, responsible boundaries to name a few. Pastoral reflection directs the student in the use of collaboration with other professionals, and self and peer evaluation in providing ministry to others.

The ACPE, Inc. maintains rigorous standards for its educational programs, all of which are reviewed in one-year, five-year and ten-year cycles to assure quality, integrity and consistency. Our standards are reviewed annually for adequacy and relevance to the field. Further, they are revised every five years in conjunction with our application for re-recognition by the United States Department of Education.

A copy of the ACPE training standards (which includes our objectives and outcomes for Clinical Pastoral Education) is included with this response. We are also including a copy of the Common Standards for Professional Chaplaincy and our Code of Ethical Conduct adopted by the Council on Collaboration in 2004, which provides a unified voice of the six largest professional spiritual care groups in the United States and Canada. The membership of these groups represents over 10,000 members who currently serve as chaplains, pastoral counselors, and clinical pastoral educators in specialized settings, including hospice and other healthcare organizations, counseling centers, prisons, or the military.

By including standards that require the employment of a trained and Board Certified spiritual care professionals, the proposed CMS Rules would ensure that those providing spiritual care to hospice patients, families, and staff would be held accountable just as other professional, licensed staff are. This protects hospice patients, family, and staff with unwanted, intrusive, and potentially abusive spiritual interventions by those who are not professionally trained, certified, nor held accountable to professional standards of practice and ethics.

While community religious leaders provide gifts in the provision of religious care to hospice patients and families, professionally trained and certified spiritual care providers

bring to the hospice environment the skills to provide spiritual assessment, an outcome-based spiritual plan of care and interventions based on professional spiritual care standards of practice, the ability to work effectively within an interdisciplinary team, and specialty in loss, grief, and bereavement care and counseling. Board certified chaplains work with community religious leaders to facilitate their care to their religious community members, while also serving as an educator and facilitator of the hospice environment and specialist in the unique spiritual and emotional needs of hospice patients and families.

We recommend that standards be included to require hospices to employ trained and certified professional chaplains in order to meet clearly and effectively the proposed rules including:

Proposed 418.52: PATIENT RIGHTS

Professionally trained and nationally certified spiritual care providers are advocates for patient rights, educators for patients, families, and hospice staff, and are trained to provide spiritual care to those seeking to make treatment and end of life decisions.

Proposed 418.54: COMPREHENSIVE ASSESSMENT OF THE PATIENT

Board certified chaplains are trained to provide spiritual assessments that identify issues, interventions, and specific outcomes to meet the unique needs of each hospice patient and their family. Additionally, board certified chaplains are trained in how to document in both clinical and progress notes in ways that articulate clearly to the entire interdisciplinary team what spiritual issues may impact the overall care of the patient and family. Professional chaplains are guided by and adhere to national standards of practice in assessment, interventions regarding spiritual distress, loss, bereavement, coping, and the use of religious and spiritual resources identified by the patient and family.

Proposed 418.56: PLAN OF CARE AND COORDINATION OF SERVICES

Professionally trained and nationally trained spiritual care providers have extensive training and experience in developing and writing an outcome-based written spiritual plan of care for patients and families and working with interdisciplinary group care planning and coordination of services.

Proposed 418.58: QAPI

Board certified chaplains not only have training in quality assessment and performance improvement, but also have shown value to organizations that they serve in actively participating and maintaining QI and PI planning and projects. All work of board certified chaplains is informed and guided by professional practice standards applicable to hospice care.

Proposed 418.78 VOLUNTEERS

Clinically trained and nationally certified professional spiritual care providers are skilled in the training and oversight of volunteers, particularly those who seek to provide emotional and spiritual care to hospice patients and families. Having a board certified chaplain in this role assures the hospice of maintaining patient rights and providing appropriate care by volunteers.

Proposed 418.100 ORGANIZATION AND ADMINISTRATION

Again, board certified chaplains are trained and professionally credentialed and follow national standards of practice in order to organize, manage, and administer spiritual services to patients, caregivers, and families within the hospice environment while maintaining dignity, comfort, and advocacy for patient/family needs and desires. Board certified chaplains serve as educators to other professional staff and volunteers in areas of patient rights, advance care planning, end of life, and spiritual, religious, and cultural needs.

INCLUSIVE SPIRITUAL AND RELIGIOUS LANGUAGE

We strongly encourage the Proposed Rules be adapted to utilize language that is inclusive of persons of all spiritual and religious traditions. Rather than using the word 'clergy' (which is a Christian term) in the Proposed Rules, we suggest the use of the word "Board Certified Chaplain" for those employed by the hospice and "community religious leaders" for those who serve as community support and/or volunteers.

CULTURAL ISSUES

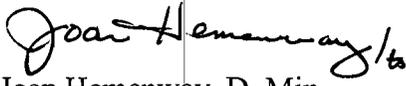
We also strongly encourage that the proposed rules be attentive in the inclusion of additional language addressing the cultural needs of patients and families. It is important to all patients, especially when dealing with the stresses of a terminal diagnosis and end of life, that their rights be respected in all areas of life. For many of differing cultural and spiritual backgrounds, the issues of diet, space for cultural, spiritual, and/or religious ritual, medication and other treatments, the inclusion of complementary therapies, and conversations around diagnosis, treatment, and death are essential dimensions of patient rights.

Thank you for this opportunity for us to comment on CMS-3844-P, the new proposed rules for hospice and for your consideration of our concerns. Do not hesitate to contact the Association for Clinical Pastoral Education, Inc. if we can provide more information regarding clinical pastoral education or the training of professional chaplains.

Page 5 of 5
ACPE, Inc. Response to CMS-3844-P
June 30, 2005

Respectfully submitted,


Arthur Schmidt, D. Min, BCC
ACPE President


Joan Hemenway, D. Min.
ACPE President-Elect


Teresa E. Snorton, D. Min., BCC
ACPE Executive Director

ATT: ACPE Standards (2005)
Common Standards for Professional Chaplaincy
Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators,
and Students

ACPE

Standards of the Association for Clinical Pastoral Education, Inc.

2005

Standards Committee
Association for Clinical Pastoral Education, Inc.
1549 Clairmont Road, Suite 103
Decatur, Georgia 30033
(404) 320-1472
www.acpe.edu



Hospice &
Palliative Care
Federation of Massachusetts

11
July 13, 2005

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-3844-P
PO Box 8010
Baltimore, MD 21244-8010

Dear Sir/Madam:

Thank you for this opportunity to comment on the Medicare and Medicaid Programs: Hospice Conditions of Participation; Proposed Rule which appeared in the Federal Register on May 27, 2005. The Hospice & Palliative Care Federation is a non-profit organization, established in 1980, whose membership includes 45 licensed hospices in Massachusetts as well as other organizations and individuals who share our mission of advancing and promoting excellence in end of life care.

In general, hospice providers have found the new organization of the proposed CoPs helpful and more user friendly. For the most part, new standards are consistent with the hospice community's interest in assuring quality and encouraging a greater degree of uniformity among hospice programs. We will provide comment on those standards which we feel need further clarification or where the standards may pose implementation problems for hospices in Massachusetts. In addition, we have **highlighted our priority issues in bold type**.

Other General Comments

- Well-organized with new structure -- Patient Care followed by Administrative Standards
- The Nurse Practitioner's role as an attending physician should be included and clarified throughout
- The impact analyses appears to minimize time and cost on most activities
- Palliative Care was not focused upon enough to help move hospice "upstream"
- Concern that the Interpretative Guidelines falling from the CoPs be clear so that differences in interpretation and enforcement by regions is minimized
- The greater flexibility to choose appropriate practices is appreciated

418.3 Definitions

Clinical note - Change to include *spiritual* changes

Drug restraint - Clarification needed. At end of life (EOL), certain medications can be standard treatment to manage terminal agitation or to induce sedation for those experiencing intractable suffering. Surveyors who are not expert in EOL care may view this as a drug restraint rather

than as acceptable practice. Surveyors and hospices will have to agree to the definition of "standard treatments" used at end of life in order to assure that there are options for controlling symptoms not responsive to conventional treatment.

Hospice care - should include that "hospice means a comprehensive set of services provided in the home, in the community and in facilities, identified and coordinated by an interdisciplinary team...." Despite memos from CMS to the contrary, some facilities are becoming licensed as hospice programs with no intention of caring for other than their own residents. This dilutes the foundation hospice philosophy of providing care across all settings wherever the patient's home may be and is a risk to potential fraud and abuse.

Satellite location - needs further clarification. With the growth of corporations with multiple entities within a state, Medicare should be clear about what criteria a "satellite" must meet if it is to use a single provider number to establish other hospice programs. Criteria might include shared staffing, level of administration on site, and distance of service area from main office. Clarification on the survey process/time frame for the approval process is also requested.

418.52 Patient's rights

(a) *Notice of rights*

(1) *Translation* - requirement for written translation could provide problems for hospices in urban areas with significant multi-cultural populations.

(3) *Information about tracking and disposal of controlled substances* - Informing families about drug policies at the time of admission will be confusing and potentially terrifying to families already concerned about having controlled substances in the home. Given how much information is already conveyed during the admission visit, information about drug policies may be better provided during the assessment visit rather than admission. Explanations in a patient handbook should suffice until further explanation is appropriate. Language should consistently state "controlled substances" rather than "narcotics."

(b) *Exercise of rights and respect for property/person*

(1) Should include right to refuse treatment

(4) Should use language from Home Health CoPs more appropriate to home setting

(e) *Patient liability* - Use of ABN form for hospice is still confusing.

418.54 Comprehensive assessment of the patient

(a) ***Initial assessment*** - requirement for assessment within 24 hours is not practical. About half of hospice referrals come from non-physician sources and is not subject to an attending physician's order. Even with a physician referral, the first physician order may be for a consult not for an admission. Whatever the source of the referral, the family/patient decides and controls when the admission takes place as the patient must elect the benefit. Language might be revised to "make available to the family a visit within 24 hours" or "as otherwise requested by the family," or "contact" rather than "visit."

We also recommend that the CoPs allow the initial assessment of the patient to be carried out by other than an RN, such as by the social worker, as long as the nursing assessment be done by the RN within 24 hours. Many hospices currently allow this practice.

(b) *Time for completion of comprehensive assessment* - 4 calendar days is a realistic time frame and necessary given that 1/3 of hospice patient die within 7 days.

(e) *Patient outcome measures* - While it is a desirable goal to have “systematic and retrievable” data for each patient, implementation will be very difficult for hospices without computerized clinical record systems. Many hospices in Massachusetts do not have the financial resources to purchase these expensive computerized systems. Since EOL/hospice outcomes have not been accepted to date by the National Quality Forum, it will take leadership and research on the part of CMS and the National Hospice & Palliative Care Organization to identify, test, and standardize a reliable set of indicators to determine quality. A phase-in period for this standard is recommended.

418.56 Interdisciplinary group care planning

(a) (1) *Approach to service delivery* - There was consensus that a qualified licensed professional could coordinate a patient’s plan of care, thus lessening the burden on RN responsibilities. However, in many hospices, this would require a significant culture shift.

(c) (6) *Content of the PoC*. - There should be **no** requirement that the **family** agree with the PoC as the patient’s wishes should prevail. Further clarification is needed if the patient is not competent and there is disagreement among family members. In Massachusetts, the patient’s appointed health care proxy makes the health care decisions.

(d) *Review of the PoC* - The requirement for the Hospice Medical Director to collaborate with the attending physician is desirable but not always practical given time, interest of the attending and the resources of the hospice program. “To the extent possible” is acceptable language.

418.58 Quality assessment and performance improvement

Performance measures for hospice and EOL are not agreed upon or uniformly used within the provider community and computerized systems are not consistently available for efficient collection and summary of data.

(c) (2) *Program activities* - An adverse event is sometimes defined as an “unexpected death or an incident that has serious consequences.” An example would be the unlawful diversion of medication leading to the death of other than the patient outside the home.

(e) (2) *Executive responsibility* - QA/PI outcomes should be shared on a regular basis with the governing body of the hospice program.

418.64 Core Services

(a) Allowing the primary hospice to enter into arrangement with another Medicare certified hospice to obtain core services out of area for routine travel is very helpful. However, when the patient remains in the hospice’s own service area or when a hospice has extraordinary staffing needs due to unusual vacancies, a number of difficulties may be presented. For instance, in non-CON/DON states, the limiting of arrangements to contracting only with another certified hospice, would put hospices in the position of being required to contract with competing

hospices and thus may raise conflict of interest concerns. In addition, since hospices in non-CON/DON states have overlapping service areas. Recruitment problems for one hospice program may extend to other hospices in the same area. Hospices should be allowed to contract with other staffing resources such as home health agencies, nursing staff agencies, or counseling agencies as long as they ensure that competencies and skills of contracted staff and maintain professional responsibility for the care they provide.

(d) (3) (iii) *Spiritual counseling* - Revise language "hospice need not go to extraordinary lengths to do so." If spiritual care is important enough to be a core service, the hospice should try hard to arrange it.

418.66 Nursing services

(a) For purposes of waiver, what is the definition of a non-urbanized area?

418.76 Home health aide and homemaker services.

(h) *Supervision of HHA* -this standard requires clarification. Is this a Human Resource function such that EACH HHA must be supervised for job performance or is it the patient's Plan of Care that is being supervised? If the former, this will pose a substantial coordination and operational challenge since there may be more than one HHA caring for the patient's length of stay in hospice care.

Further, it is not clear whether the requirement for on-site supervision of the HHA every 28 days is in addition to the requirement for supervision every 14 days.

418.100 Organization and administration of services

(a) (2) *Serving the hospice patient and family* - Change language from "consistent with patient and family needs and desires" to "consistent with the patient's goals." The former language leaves the door open to futile and unrealistic treatment and interventions. Patient preferences should have priority in situations where there are conflicts in the family. In addition, the limited availability and reliability of outcome measures to date to satisfy this requirement should be considered as well as the challenges of auditing the family's satisfaction.

(e) *Professional management responsibility* - The hospice should have professional oversight responsibility for the services provided but not the staff. That responsibility belongs to the SNF.

(f) *Satellite locations* - With the growing number of corporations with multiple entities opening hospice programs using the same provider number, the definition of satellite should be clarified so that it is consistent across regions and not subject to interpretation. The process for determining approval of the satellite needs to be further clarified.

418.102 Medical Director

(c) *Coordination of medical care* - It is neither realistic nor appropriate for a medical director to be responsible for directing the hospice's QA/PI program. The average hospice medical director has not the time, the training or the interest in administering such a program. In Massachusetts, there are only two full time HMDs in the state. All other hospice programs use the services of a medical director on a part time basis and those

hours are used for clinical consultation, IDT involvement and direct patient care.

For the QA effort, the Hospice Medical Director should have involvement but not primary responsibility.

418.104 Clinical records

(b) *Authentication* - this is not practical for home hospice care and the financial impact would be significant.

(e) *Discharge and transfer of care* - facilities do not want to receive a complete copy of the patient's clinical record. This is not done in any other aspect of health care. A detailed discharge summary is acceptable and consistent with HIPAA standards to provide the minimum information necessary.

418.105 Drugs, controlled substances....

(b) *Controlled drugs in the patient's home* - language should be revised to "safety of controlled substances" rather than "potential dangers" of their use. It is challenging enough to have the family comfortable with controlled substances in the home without reinforcing social stigmas. The hospice policy for the use of the drugs and their disposal should be stated in the hospice's printed materials but not necessarily discussed at the initial visit.

(c) (1) *Use of DME* - the DME vendor, not the hospice, should be responsible for the repair and routine maintenance policies and procedures with the hospice responsible for the professional management of the contract.

418.108 Short-term inpatient care

General inpatient care should be appropriate and available to families who are experiencing a short-term crisis of a psychosocial nature as well as for an acute symptom condition that requires 24 hour skilled nursing care. Criteria for the use of GIP and respite should be clearly defined and separate in their requirements as this is a point of misunderstanding by professionals and the public.

(a) *Inpatient care for symptom management and pain control* - The CoPs should retain the requirement that an RN be on-site 24/7 at facilities providing the GIP either as freestanding units or as contracted facilities. GIP, as the most acute level of hospice care, warrants the expertise and care of an RN to monitor pain and symptoms deemed unmanageable at the routine home level of care.

(b) *Respite* - for this level of care, we agree that an RN providing direct care 24/7 is not needed on-site in the facility as respite care is primarily for care giver relief and the patient is usually stable.

(c) (3) A copy of the entire medical record is not needed, only a discharge summary.

418.110 Hospice providing inpatient care directly

(b) *Staffing* - an RN should be on-site 24 hours a day to provide direct patient care.

(o) *Seclusion and restraint* - As stated in *Definitions*, clarification and mutual understanding is needed here. At end of life (EOL), certain medications can be standard treatment to manage

terminal agitation or induce sedation for those experiencing intractable suffering. When certain drugs are used to manage the treatment of a single symptom, it is not the same as using the drug for "restraint." Surveyors who are not expert in EOL care may view such treatment as a drug restraint rather than acceptable practice. As an example, Mrs. S. has advanced cancer and a prognosis of just a few days. She is being treated with high doses of Risperidol for terminal agitation as she has become severely agitated, exhibiting violent behavior toward her family. Her family was extremely distressed by this unusual behavior from such a gentle person. Mrs. S' medication was titrated to treat the terminal agitation and its resulting violent behavior, the symptom was eliminated and she died peacefully with her family at her side.

Surveyors and hospices will have to agree to the definition of "standard treatment" in end of life care in order to assure there are adequate options for symptoms not responsive to conventional treatment.

418.112 Hospice in the SNF

(d) *Medical director* - the requirement for communication between the hospice medical director, attending physician, SNF medical director and other physicians is burdensome and may restrict access to hospice for nursing home residents. The coordination with the SNF medical director, attending physician and other consulting physicians should be encouraged where feasible and when the parties have expressed a desire to be directly involved in the patient's care.

(I) *Orientation and training of staff* - Training of SNF staff by hospice is critical to the care of the nursing home resident in hospice care. However, depending on the number of hospice contracts held by the SNF, it may be impractical for all hospices to be required to provide training without overwhelming SNF staff. Wording should be " 'must assure' orientation of facility staff."

418.114 Personnel qualifications

(c) (7) *Social worker* - there was consensus that the minimum education requirement for a direct care social worker should be a MSW degree as the level of clinical judgement and independence required in the culture and environment of a person's home comes only through experience, education and training. However, a waiver exemption should be afforded where the hospice can show undue difficulty in recruiting a master's prepared social worker.

(d) *Criminal background checks* - CORI checks should be required for all direct care hospice staff and volunteers. This is already required by Mass. statute for all direct care staff and volunteers in health care settings.

418.116 Compliance with Federal, State and local laws

(b) *Multiple locations* - see comments on satellites in Definitions (418.3) and Organization and Administration of Services (418.100)

We appreciate the opportunity to offer these comments to CMS on behalf of Massachusetts hospices and hope that the implementation process will move ahead to provide updated, fresh and clear rules to guide care to individuals at the end of life.

Sincerely,

A handwritten signature in cursive script that reads "D. Rigney Cunningham". The signature is written in black ink and is positioned above the printed name.

D. Rigney Cunningham, MSW
Executive Director

**STANDARDS of the
Association for Clinical Pastoral Education, Inc.
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Preface

Richard C. Cabot conceived of **clinical pastoral education (CPE)** as a method of learning pastoral practice in a clinical setting under **supervision**. Anton T. Boisen enlarged the concept to include a case study method of theological inquiry -- a study of "living human documents." William S. Keller began supervising theological **students** in case study methods, believing pastoral practice was complete only as it addressed contributing social conditions. As CPE developed, other leaders opened the doors to integrating knowledge from medicine, psychology and other behavioral sciences into pastoral practice.

The Association for **Clinical Pastoral Education, Inc. (ACPE)** formed in 1967 after some forty years of experience, development and practice of **clinical pastoral education** by several organized but uncoordinated groups. The groups merging to form ACPE included the Institute of Pastoral Care, Inc., the Council for Clinical Training, Inc., the Association of Clinical Pastoral Educators, and the **certification and accreditation** functions of the Lutheran Council in the U.S.A.

Thus ACPE became the **standard setting, accrediting, certifying resource agency** in the field of **clinical pastoral education**. It accredits institutions, agencies and parishes as **clinical pastoral education centers** to offer programs of **clinical pastoral education** and certifies **supervisors** to conduct these programs.

ACPE accredited centers offer **clinical pastoral education** as: part of theological education; training for pastoral ministry; training for institutional chaplaincy; training for pastoral counseling; training for **certification as a supervisor of clinical pastoral education**; and training for other specialized ministries. Theological schools give academic credit for **clinical pastoral education** according to the credit system of each school.

NOTE: Throughout the manual, bold text indicates a term defined in the glossary; text in italics is for emphasis.

**STANDARDS
of the
Association for Clinical Pastoral Education, Inc.**

Part One -- Introduction

I. Mission of the Association for Clinical Pastoral Education, Inc. (ACPE)

The Association for **Clinical Pastoral Education, Inc. (ACPE)** is a professional association committed to advancing experience-based theological education for seminarians, clergy and lay persons of diverse cultures, ethnic groups and faith traditions. ACPE establishes **standards**, certifies **supervisors** and accredits centers to provide programs of **clinical pastoral education (CPE)** in varied settings. ACPE approved programs promote the integration of personal history, faith tradition and the behavioral sciences in the practice of spiritual care.

II. Philosophy for Promulgation of Standards

As a professional association, ACPE has responsibility to the public to define **standards** of conduct for **members** and promulgate **standards** for education and **certification** in **clinical pastoral education** to safeguard the public and to help assure quality education for and competence of practitioners.

III. Standards Committee

A. Function and authority

The **Standards Committee**, responsible to the ACPE Board of **Representatives**, recommends to the Board **standards** for ethical conduct of **members**, **clinical pastoral education (CPE)**, **accreditation** of centers to offer programs of CPE, and **certification** of supervisors. The Board, after considering the recommendations of the **Standards Committee**, sets the **standards** for ethical conduct, **clinical pastoral education**, **accreditation** of programs to provide CPE, and **certification** of supervisors.

The **Standards Committee** develops recommendations for **standards** based on input from the ACPE **Accreditation, Certification and Professional Ethics Commissions**, ACPE **members**, constituents, cognate groups, care recipients, and the public. The **Standards Committee** also develops mechanisms for feedback and review of the respective **Commissions'** manuals every five years.

B. Composition

The **Standards Committee** is comprised of ten **members**, a **representative** from each of the nine regions and a chair. **Members** are elected for a three year term, with one-third elected each year. **Members** are elected by the Board of **Representatives** upon nomination by the Representation and Nomination Committee from the candidate(s) suggested by each region.

Part Two -- Standards

Standard 100 Code of Professional Ethics for ACPE Members

Maintenance of high standards of ethical conduct is a responsibility shared by all ACPE members and students.

ACPE members agree to adhere to a standard of conduct consistent with the code of ethics established in ACPE standards. Members are required to sign the *Accountability For Ethical Conduct Policy Report Form* (Appendix 1) and to promptly provide notice to the ACPE Executive Director of any **complaint** of unethical or felonious conduct made against them in a civil, criminal, ecclesiastical, employment, or another professional organization's forum.

Any ACPE member may invoke an ethics, accreditation or certification review process when a member's conduct, inside or outside their professional work involves an alleged abuse of power or authority, involves an alleged felony, or is the subject of civil action or discipline in another forum when any of these impinge upon the ability of a member to function effectively and credibly as a CPE supervisor, chaplain or spiritual care provider.

Standard 101 In relationship to those served, ACPE members:

- 101.1 affirm and respect the human dignity and individual worth of each person.
- 101.2 do not discriminate against anyone because of race, gender, age, faith group, national origin, sexual orientation, or disability.
- 101.3 respect the integrity and welfare of those served or supervised, refraining from disparagement and avoiding emotional exploitation, **sexual exploitation**, or any other kind of exploitation.
- 101.4 approach the religious convictions of a person, group and/or CPE student with respect and sensitivity; avoid the imposition of their theology or cultural values on those served or supervised.
- 101.5 respect confidentiality to the extent permitted by law, regulations or other applicable rules.
- 101.6 follow nationally established guidelines in the design of research involving human subjects and gain approval from a recognized institutional review board before conducting such research.

Standard 102 In relation to other groups, ACPE members:

- 102.1 maintain good standing in their faith group.
- 102.2 abide by the professional practice and/or teaching **standards** of the state, the community and the institution in which they are employed. If, for any reason they are not free to practice or teach according to conscience, they shall notify the employer and ACPE through the regional director.
- 102.3 maintain professional relationships with other persons in the **ACPE center**, institution in which employed and/or the community.
- 102.4 do not directly or by implication claim professional qualifications that exceed actual qualifications or misrepresent their affiliation with any institution, organization or individual; are responsible for correcting the misrepresentation or misunderstanding of their professional qualifications or affiliations.

Standard 103 In relation to ACPE, members:

- 103.1 continue professional education and growth, including participation in the meetings and affairs of ACPE.
- 103.2 avoid using knowledge, position or professional association to secure unfair personal advantage; do not knowingly permit their services to be used by others for purposes inconsistent with the **ethical standards** of ACPE; or use affiliation with ACPE for purposes that are not consistent with ACPE standards.
- 103.3 speak on behalf of ACPE or represent the official position of ACPE only as authorized by the ACPE governing body.
- 103.4 do not make intentionally false, misleading or incomplete statements about their work or ethical behavior when questioned by colleagues.

Standard 104 In collegial relationships, ACPE members:

- 104.1 respect the integrity and welfare of colleagues; maintain professional relationships on a professional basis, refraining from disparagement and avoiding emotional, sexual or any other kind of exploitation.
- 104.2 take collegial and responsible action when concerns about incompetence, **impairment** or misconduct arise.

Standard 105 In conducting business matters, ACPE members:

- 105.1 carry out administrative responsibilities in a timely and professional manner.
- 105.2 implement sound fiscal practices, maintain accurate financial records and protect the integrity of funds entrusted to their care.
- 105.3 distinguish private opinions from those of ACPE, their faith group or profession in all publicity, public announcements or publications.
- 105.4 accurately describe the ACPE center, its pastoral services and educational programs. All statements in advertising, catalogs, publications, recruiting, and academic calendars shall be accurate at the time of publication. Publications advertising a center's programs shall include the type(s) and level(s) of education offered, and the ACPE address, telephone number and website address.
- 105.5 accurately describe program expectations, including time requirements, in the admissions process for CPE programs.

Standard 200 Complaints

ACPE encourages persons to work out concerns or grievances informally, face-to-face, and in a spirit of collegiality and mutual respect. If differences are not resolved, a **complaint** involving an alleged violation of the ACPE ethical or professional standards may be registered in accordance with the procedures set forth in the manual *Processing Complaints of Ethics Code Violations*.

The Professional Ethics **Commission** has final authority to determine whether violations of ACPE standards have occurred and to determine final disposition of **complaints**. Policies and **procedures** for registering a **complaint**, conducting mediation and hearings, and disposing of **complaints** are found in *Processing Complaints of Ethics Code Violations*.

Standard 300 Accreditation

The **Accreditation Commission** establishes procedures and guidelines, detailed in the *ACPE Accreditation Manual*, for granting and maintaining the accreditation of an ACPE center and its programs. The **Accreditation Commission** has authority to take action on all accreditation matters, including granting, deferring, denying, suspending, or withdrawing accreditation for any center, subject to the ACPE appeal process.

301-306 ACPE Accredited Centers

All ACPE Accredited Centers shall:

Standard 301 develop and maintain a written plan which:

- 301.1 describes the administrative structure and lines of authority within the center.
- 301.2 provides for compliance with ACPE standards.
- 301.3 describes how commitments to students will be met in the event of substantial change within the institution or center.

Standard 302 provide at least the following components:

- 302.1 financial, human and physical resources sufficient to support the units of CPE offered by the center.
- 302.2 a population that provides students with opportunities for ministry and clinical pastoral education.
- 302.3 a written agreement that specifies the relationship and operational details between the center and any agency(ies) whenever a program uses elements from any agency(ies) external to itself.

Standard 303 provide these educational resources:

- 303.1 a faculty of sufficient size to fulfill program goals and comprised of persons authorized by ACPE. A center's faculty must include at least one supervisor certified by ACPE as Associate Supervisor or ACPE Supervisor.
- 303.2 a faculty development plan.
- 303.3 interdisciplinary consultation and teaching within the program(s) provided by adjunct faculty and/or guest lecturers.
- 303.4 individual and group supervision by a person authorized by ACPE.
- 303.5 a peer group of at least three CPE (Level I/II) students engaged in small group process and committed to fulfilling the requirements of the educational program.
- 303.6 access to library and educational facilities adequate to meet the the ACPE standards.

303.7 access to current ACPE standards and commissions' manuals.

303.8 student support services including, but not limited to, orientation, a process for educational guidance and recommendations for counseling resources, resume preparation and employment search.

Standard 304 provide all policies and procedures in writing and inform all students and ACPE program staff of their content. These include, but are not limited to:

304.1 an admission policy that clearly states the ACPE accredited center does not discriminate against persons because of race, gender, age, faith group, national origin, sexual orientation, or disability.

304.2 a financial policy that clearly states fees, payment schedules, refunds, stipends, and benefits.

304.3 a complaint procedure consistent with ACPE standards and the ACPE manual *Processing Complaints of Ethics Violations*.

304.4 a procedure for maintaining student records for ten years, which addresses confidentiality, access, content, and custody of student records should the center be without a supervisor and/or accreditation. (See *Guidelines for Student Records*, Appendix 12, *ACPE Accreditation Manual*.)

304.5 a procedure for providing consultation for CPE students.

304.6 a procedure for discipline, dismissal and withdrawal of students.

304.7 a policy for ethical conduct of students and program staff consistent with the ACPE Code of Ethics.

304.8 a statement of student rights and responsibilities.

304.9 an agreement for training at the ministry site that includes, but is not limited to:

- authorization to visit patients, parishioners or clients;
- access to appropriate clinical records and informed consent with regard to use of student materials; and
- agreement by the student to abide by center policies protecting confidentiality and rights of clients/patients/parishioners.

304.10 a policy and procedure that provides for completion of a unit or program in process if the supervisor is unable to continue.

Standard 305 have **consultation** and program evaluation, including:

- 305.1 an on-going process of **consultation** with a designated professional advisory group.
- 305.2 on-going program evaluation sufficient to promote the continuous quality improvement of the educational program(s) including:
- course content and materials;
 - success with respect to **student** achievement, including course completion, **certification** rate and job placement;
 - educational methods and **supervisory** relationship;
 - **student** to **supervisor** ratio;
 - appropriate level of challenge in individual learning contracts;
 - assessment of **students'** use of CPE.

Standard 306 accurately describe the center, its pastoral services and educational programs.

- All statements in advertising, catalogs, publications, recruiting, and academic calendars shall be accurate at the time of publication.
- Publications that advertise a center's programs shall include the type(s) and level(s) of education offered and the ACPE mailing address, telephone number and website address.

307-308 ACPE Accredited Programs

Standard 307 An applicant's suitability for **admission** to any CPE program is a matter of judgment by the ACPE accredited center in accordance with its **admission** policies. Requirements for **admission** to CPE programs include, but are not limited to:

- 307.1 a completed ACPE application.
- 307.2 an **admission** interview with a **qualified** interviewer for persons applying for an initial unit of CPE to determine readiness for clinical learning.
- 307.3 either graduation from high school/completion of a GED or ordination by a faith community or **commission** to function in ministry by an appropriate religious authority as determined by ACPE.
- 307.4 fulfillment of education or experience requirements established by the ACPE accredited center.

307.5 acceptance by an **ACPE accredited center** accredited for appropriate program type.

307.6 Additional requirements for **admission** to Supervisory CPE include, but are not limited to:

307.6.1 previous ministry experience in which the applicant demonstrated ability to function pastorally.

307.6.2 successfully meeting **CPE Level II** outcomes.

307.6.3 **consultation for readiness** for the **student and supervisor** as specified in the ACPE *Certification Manual*, Part Two, IV. A.

307.6.4 ACPE membership.

Standard 308 Program standards include:

308.1 a specific time period for a **program unit of clinical pastoral education** or a half unit of **clinical pastoral education**.

- A unit of CPE is at least 100 hours of structured group and individual education. Each unit shall be accompanied by the supervised, clinical practice in ministry. The combined time shall be no less than 400 hours.
- A half unit of CPE is at least 60 hours of structured group and individual education. Each half unit shall be accompanied by the supervised, clinical practice in ministry. The combined time shall be no less than 240 hours.

308.2 supervised clinical practice of ministry to persons and the detailed reporting and evaluation of that ministry.

308.3 **supervision** by a person **authorized** by ACPE.

308.4 an individual **contract** for learning developed collaboratively by the **student and supervisor**.

308.5 a relational learning environment that fosters growth in pastoral formation, pastoral reflection and pastoral competence; such an environment involves mutual trust, respect, openness, challenge, conflict, and confrontation.

308.6 an instructional plan that employs a **process model of education** and **clinical method of learning** including:

308.6.1 delineation and use of **students' goals**.

308.6.2 **core curriculum** appropriate to the CPE setting.

308.6.3 clearly written syllabus.

308.6.4 evidence of congruence between program goals and the mission of the institution.

308.6.5 program evaluation by the **students**.

308.7 presentation and use of literature and instruction appropriate to the **students' learning goals and needs**.

308.8 final evaluations written by the **student and supervisor**.

308.8.1 **Supervisor's** evaluation will be available to the **student** within 45 calendar days of the completion of the unit.

308.8.2 **Supervisor's** assessment reflects professional judgment about **student's** work, abilities, strengths, weaknesses.

308.8.3 **Supervisor** certifies completion of a unit or half unit of **CPE (Level I/II)**.

308.8.4 **Student** may attach a written response to the **supervisor's** evaluation, which then becomes part of the **student's** record.

309-319 Objectives and Outcomes of ACPE Accredited Programs

CPE provides theological and professional education using the **clinical method of learning** in diverse contexts of ministry. ACPE accredits two types of **clinical pastoral education** programs: **CPE (Level I/Level II)** and Supervisory CPE. ACPE accredited programs provide a progressive learning experience through a two level **curriculum**. Level I curriculum outcomes must be satisfactorily addressed prior to admission to Level II. Completion of **CPE (Level I/Level II)** curriculum outcomes is prerequisite for **admission** to Supervisory CPE.

309-310 Objectives of CPE (Level I/Level II)

CPE (Level I/Level II) enables pastoral formation, pastoral competence, and pastoral reflection. Some CPE centers offer pastoral specialization(s) as part of their Level II curriculum.

CPE (Level I/Level II) objectives define the scope of the CPE (Level I/Level II) program curricula. Outcomes define the competencies to be developed by students as a result of participating in each of the programs.

Standard 309 The center designs its CPE (Level I/Level II) curriculum to facilitate the students' achievement of the following objectives:

Pastoral Formation

- 309.1 to develop **students'** awareness of themselves as ministers and of the ways their ministry affects persons.
- 309.2 to develop **students'** awareness of how their attitudes, values, assumptions, strengths, and weaknesses affect their pastoral care.
- 309.3 to develop **students'** ability to engage and apply the support, confrontation and clarification of the **peer group** for the integration of personal attributes and pastoral functioning.

Pastoral Competence

- 309.4 to develop **students'** awareness and understanding of how persons, social conditions, systems, and structures affect their lives and the lives of others and how to address effectively these issues through their ministry.
- 309.5 to develop **students'** skills in providing intensive and extensive pastoral care and counseling to persons.
- 309.6 to develop **students'** ability to make effective use of their religious/spiritual heritage, theological understanding, and knowledge of the behavioral sciences in their pastoral care of persons and groups.
- 309.7 to teach **students** the pastoral role in professional relationships and how to work effectively as a pastoral **member** of a multidisciplinary team.
- 309.8 to develop **students'** capacity to use one's pastoral and prophetic perspectives in preaching, teaching, leadership, management, pastoral care, and pastoral counseling.

Pastoral Reflection

309.9 to develop **students'** understanding and ability to apply the **clinical method of learning**.

309.10 to develop **students'** abilities to use both individual and group **supervision** for personal and professional growth, including the capacity to evaluate one's ministry.

Standard 310 Where a pastoral care specialty is offered, the CPE center designs its **CPE Level II curriculum** to facilitate the **students'** achievement of the following additional objectives:

310.1 to afford **students** opportunities to become familiar with and apply relevant theories and methodologies to their ministry specialty.

310.2 to provide **students** opportunities to formulate and apply their philosophy and methodology for the ministry specialty.

310.3 to provide **students** opportunities to demonstrate **pastoral competence** in the practice of the specialty.

Standard 311-312 Outcomes of CPE (Level I/Level II) Programs

Standard 311 Outcomes of CPE Level I

The curriculum for **CPE Level I** addresses the fundamentals of **pastoral formation, pastoral competence and pastoral reflection** through one or more **program units**. Satisfactory achievement of Level I outcomes must be documented in the **supervisor's** evaluation(s).

At the conclusion of **CPE Level I** students are able to:

Pastoral Formation

311.1 articulate the central themes of their religious heritage and the theological understanding that informs their ministry.

311.2 identify and discuss major life events, relationships and cultural contexts that influence personal identity as expressed in pastoral functioning.

311.3 initiate **peer group** and supervisory **consultation** and receive critique about one's ministry practice.

Pastoral Competence

311.4 risk offering appropriate and timely critique.

311.5 recognize relational dynamics within group contexts.

311.6 demonstrate integration of conceptual understandings presented in the **curriculum** into pastoral practice.

311.7 initiate helping relationships within and across diverse populations.

Pastoral Reflection

311.8 use the clinical methods of learning to achieve their educational goals.

311.9 formulate clear and specific goals for continuing **pastoral formation** with reference to personal strengths and weaknesses.

Standard 312 Outcomes of CPE Level II

The **curriculum** for **CPE Level II** addresses the development and integration of **pastoral formation**, **pastoral competence** and **pastoral reflection** to a level of competence that permits **students** to attain professional **certification** and/or **admission** to Supervisory CPE. The Level II **curriculum** involves at least two or more program units of CPE. **Supervisors** must document satisfactory completion of **CPE Level II** curriculum outcomes in the **supervisor's** final evaluation(s).

At the conclusion of **CPE Level II** **students** are able to:

Pastoral Formation

312.1 articulate an understanding of the pastoral role that is congruent with their personal values, basic assumptions and personhood.

Pastoral Competence

312.2 provide pastoral ministry to diverse people, taking into consideration multiple elements of cultural and ethnic differences, social conditions, systems, and justice issues without imposing their own perspectives.

312.3 demonstrate a range of pastoral skills, including listening/attending, empathic reflection, conflict resolution/confrontation, crisis management, and appropriate use of religious/spiritual resources.

312.4 assess the strengths and needs of those served, grounded in theology and using an understanding of the behavioral sciences.

312.5 manage ministry and administrative function in terms of accountability, productivity, self-direction, and clear, accurate professional communication.

312.6 demonstrate competent use of self in ministry and administrative function which includes: emotional availability, **cultural humility**, appropriate self-disclosure, positive use of power and authority, a non-anxious and non-judgmental presence, and clear and responsible boundaries.

Pastoral Reflection

312.7 establish collaboration and dialogue with peers, authorities and other professionals.

312.8 demonstrate self-supervision through realistic self-evaluation of pastoral functioning.

Standard 313 Objectives of Supervisory CPE

Through Supervisory CPE, qualified persons who have demonstrated pastoral, professional, and clinical competence will develop competence in the art, theory and practice of **supervision of clinical pastoral education**.

The objectives of Supervisory CPE define the scope of the Supervisory CPE **program curriculum**. Outcomes define the competencies that result from a **supervisory student's** participation in Supervisory CPE programs.

Standard 313 The Supervisory CPE center designs its Supervisory CPE **curriculum** to facilitate achievement of the following objectives:

313.1 to develop supervisory **students'** knowledge in theories and methodologies related to CPE **supervision** drawn from theology, professional and organizational ethics, the behavioral sciences, and adult education.

313.2 to provide **students** practice in the **supervision** of CPE under the **supervision** of an ACPE Supervisor.

313.3 to facilitate **students'** integration of the theory and practice of CPE **supervision** in their identity as a person, pastor and educator.

314- 319 Outcomes of Supervisory CPE

Standard 314 Outcomes achieved by Supervisory CPE **students** accrue in six areas of competency derived from the Supervisory CPE objectives. A successful candidate for **certification** as ACPE Associate Supervisor demonstrates the following:

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Standard 315 Competence as a pastoral supervisor:

- 315.1 maintains personal integrity and a deepening pastoral identity.
- 315.2 demonstrates emotional and spiritual maturity.
- 315.3 forms meaningful pastoral relationships.
- 315.4 self-supervises own on-going pastoral practice.
- 315.5 refines one's professional identity as a clinical pastoral educator.
- 315.6 demonstrates awareness of how one's **culture** affects professional and personal identity, pastoral practice, the supervisory relationship, and **student** learning.

Standard 316 Competence in the theories of supervision:

- 316.1 articulates understanding of and methodology for clinical **pastoral supervision** based on a critical grasp of the professional literature relating to the field of **clinical supervision**.
- 316.2 articulates and implements a philosophy of CPE based on an educational model integrating the theory and practice of CPE, which is based on and congruent with one's theology.
- 316.3 articulates rationale for multicultural competence, integrating the theory and practice of CPE, which is based on and congruent with one's theology.

Standard 317 Competence in the practice of CPE supervision including:

317.1 individual supervision

- 317.1.1 assesses an individual **student's** learning patterns, personality, and religious history as a basis for supervisory strategies.
- 317.1.2 supervises **students'** pastoral work, giving attention to unique patterns of personal and professional development, including the ability to assist **students'** movement toward pastoral identity.
- 317.1.3 defines and evaluates **students'** pastoral and personal resources, and uses supervisory strategies and

interventions to facilitate **students'** learning and development in pastoral care.

317.1.4 assists **students** in taking responsibility for formulating a learning process and evaluating the results of the learning experience.

317.1.5 uses one's personality and personal, religious and cultural history as a teaching resource in shaping a personal supervisory style.

317.2 group CPE supervision

317.2.1 facilitates development of group interpersonal interaction.

317.2.2 enables **students** to use their responses to the program as a learning experience.

Standard 318 Competence in CPE program design and implementation:

318.1 develops and organizes programs of CPE based on program educational principles appropriate to experiential learning .

318.2 manages **CPE programs** effectively.

318.3 develops a variety of **CPE program** resources.

318.4 uses diverse clinical educational methods.

318.5 works with the theological implications of the ministry context.

318.6 understands and applies professional organizational ethics as they relate to CPE and pastoral practice.

318.7 uses appropriate clinical skills and teaching methods that integrate the role of context and **culture** in pastoral practice and education.

318.8 advocates for students based on awareness of how persons' social locations, systems and structures affect one's ministry, learning and the educational context.

318.9 considers cultural factors in the use of learning assessments, educational strategies, **curriculum** resources, and evaluation procedures.

Standard 319 Competence in pastoral education:

- 319.1 integrates educational theory, knowledge of behavioral science, professional and organizational ethics, theology, and pastoral identity into supervisory function.
- 319.2 demonstrates awareness of the cultural contexts of diverse student groups and clinical populations, that integrates and articulates ethnic identity development and its implications for pastoral practice and supervisory relationships.

320 Appeal of Adverse Accreditation Decisions

Informal discussion and **consultation** are available when adverse **accreditation** decisions are rendered. Applicants seeking **accreditation** have a right to request a review of an adverse decision and a right to an orderly presentation of views when a decision is appealed.

- 320.1 The **procedures** for filing an **appeal**, designed to insure the right of fair process as defined by ACPE, are found in the ACPE *Accreditation Manual*, Appendix 7 *Appeal of Adverse Accreditation Decision(s)*.
- 320.2 An **appeal** must be based on the grounds that such decision was:
 - arbitrary, capricious or otherwise in violation of ACPE **standards** or the ACPE *Accreditation Manual*; or
 - not supported by substantial evidence in the record on which the adverse decision was based.

Standard 400 Certification

Certification by ACPE is granted by the **Certification Commission**. The **Certification Commission** establishes **procedures** and **guidelines**, detailed in the *ACPE Certification Manual*, for granting and maintaining **certification** of **CPE Supervisors**.

The **Certification Commission** has authority to take action on all **certification** matters, including: granting, denying or continuing **certification**; defining and implementing **procedures** by which **certification** may be withdrawn; and determining the limits and conditions under which a person in training may practice **supervision**. All **Certification Commission** decisions are subject to the ACPE **appeal** process.

Entry into the formal certification process requires successful completion of at least four units of **CPE (Level I/Level II)** and demonstration of having met **CPE (Level I/Level II)** outcomes. (See *ACPE Certification Manual*.)

401-404 Certification as Supervisory Candidate

Standard 401 Formal requirements include:

- 401.1 ACPE membership.
- 401.2 college graduation.
- 401.3 **Master of Divinity degree or its equivalent.**
- 401.4 **ordination or commission** to function in ministry by an appropriate religious authority as determined by ACPE.
- 401.5 **faith group endorsement.**
- 401.6 pastoral experience.
- 401.7 completion of at least one unit of Supervisory CPE.

Standard 402 Pastoral competence:

Demonstrates

- 402.1 personal integrity and pastoral identity.
- 402.2 emotional and spiritual maturity.
- 402.3 ability to form meaningful pastoral relationships.

Standard 403 Conceptual competence:

- 403.1 is familiar with diverse conceptual frameworks in pastoral theology and the behavioral and social sciences as they relate to pastoral functioning.
- 403.2 integrates knowledge, skill, theory, and practice to the end that one functions creatively, flexibly and imaginatively in pastoral ministry.

Standard 404 Potential for certification by ACPE as an ACPE Supervisor:

- 404.1 demonstrates an understanding of CPE supervision that is congruent with ACPE standards.
- 404.2 integrates personal and professional strengths and weaknesses and understands how these factors influence supervision.

405-408 Certification as Associate Supervisor

Standard 405 Formal requirements:

- 405.1 certification as Supervisory Candidate.
- 405.2 ACPE membership as a Supervisory Candidate.
- 405.3 completion of at least two units of supervised supervision of CPE as a Supervisory Candidate.
- 405.4 approval of all required theory position papers.

Standard 406 Supervisory competence:

- 406.1 completes the objectives and outcomes of Supervisory CPE.
- 406.2 chooses among methods of individual and group supervision.
- 406.3 plans, organizes and implements a unit of CPE.
- 406.4 relates to and uses interdisciplinary teaching resources.
- 406.5 critiques one's supervisory methodology based on feedback.

Standard 407 Conceptual competence:

407.1 is familiar with diverse conceptual frameworks in pastoral theology, personality theory, learning theory, group process theory, cultural anthropology, social organization, and change.

407.2 is able to articulate and integrate one's theory, skill and art of **supervision**.

407.3 knows the **ACPE standards** and the history of CPE.

407.4 is able to affirm and/or modify one's **supervision** in response to self-reflection, self-evaluation and the **consultation** of one's supervisors, peers and students.

Standard 408 Continues to demonstrate **pastoral competence** as defined in **Standard 402**.

409-410 Certification as ACPE Supervisor

Standard 409 Formal requirements:

409.1 **certification** as **Associate Supervisor**.

409.2 ACPE membership.

409.3 having conducted at least two independent units of CPE following **certification** as **Associate Supervisor**.

Standard 410 Professional competence:

Demonstrates

410.1 supervisory competence and conceptual competence as defined in **Standards 406-407**.

410.2 autonomy in CPE **supervision** that is both responsible and collegial.

411 Continuation of Supervisory Status

Standard 411 Continuation of supervisory status is contingent upon:

411.1 adhering to the ACPE Code of Professional Ethics.

411.2 demonstrating spiritual and educational growth.

- 411.3 supervising **students** in an ACPE accredited program at least once every three years or participation in other CPE-related educational activities.
- 411.4 maintaining ordination or **commission** to function in ministry by an appropriate religious authority.
- 411.5 maintaining **faith group endorsement**.
- 411.6 participating in peer review at least every five years in accordance with regional **procedures**.
- 411.7 maintaining membership in ACPE.

412 Reciprocity for CPE Supervisor Status

Procedures and guidelines for **reciprocity** shall be included in the ACPE *Certification Manual* (Part Two, IV. K). Organizations with which **reciprocity** exists are published in the **ACPE Directory**.

413 Appeal of Certification Decisions

Applicants seeking **certification** have a right to request a review of a negative decision and a right to an orderly presentation of views when a decision is appealed. **Members** of sub-committees rendering a negative **certification** decision are prohibited from discussing the dynamics of the review process with the applicant or anyone outside the committee until the time for filing an **appeal** has passed.

- 413.1 The **procedures** for filing an **appeal**, designed to insure the right of fair process as defined by ACPE, are found in the ACPE *Certification Manual*, Appendix 7, *Appeal of Negative Certification Decisions*.
- 413.2 An **appeal** must be based on the grounds that such decision was:
 - arbitrary, capricious or otherwise in violation of ACPE **standards** or the ACPE *Certification Manual*; or
 - not supported by substantial evidence in the record on which the negative decision was based.

PART THREE -- GLOSSARY

ACPE center -- an administrative structure (or entity) **authorized** by the ACPE Accreditation Commission to conduct programs of CPE (Level I/Level II) and/or Supervisory CPE. A center is responsible for providing (or contracting for) and coordinating those **components** identified by ACPE standards as necessary for clinical pastoral learning to occur. The term applies to such structures with Candidacy or Accredited Member status.

ACPE Directory -- The official ACPE listing of accredited ACPE centers and their designated programs and **supervisors**: member seminaries; denomination, faith group and agency members; network members; and international affiliate members.

Supervisors (Associate Supervisors, ACPE Supervisors, retired supervisors, Supervisory Candidates) and clinical members are listed on the ACPE website at www.acpe.edu.

ACPE Supervisor -- person **authorized** by ACPE to function autonomously to conduct CPE (Level I/Level II) and Supervisory CPE.

Accreditation -- authorization, granted by the ACPE Accreditation Commission, to conduct programs of CPE (Level I/Level II) and/or Supervisory CPE, based on demonstrated ability to meet ACPE standards. Accreditation ordinarily consists of two stages: Candidacy (pre-accreditation) and Accredited Member status. A separate accreditation is required to offer Supervisory CPE.

Accreditation review -- formal process for examining a proposed CPE center's or ACPE accredited center's compliance with ACPE standards and procedures, and for taking action on the accreditation of the center and/or its CPE program(s).

Admission -- acceptance of an applicant into a designated CPE program.

Admission interview -- the meeting of an applicant to a CPE program with a qualified interviewer to discuss the application, provide information, assess the applicant's readiness for CPE, and discuss the suitability of the center to the educational goals of the applicant. A face-to-face meeting is strongly recommended.

Appeal -- formal request for reconsideration of a decision made about ACPE certification by the Certification Commission or ACPE accreditation by the Accreditation Commission or formal challenge of a decision by a panel in the professional ethics process.

Associate Supervisor -- person **authorized** by ACPE to function as an autonomous CPE supervisor for a limited period of time and who has demonstrated to the Certification Commission: (1) successful integration of theoretical positions with supervisory practice; and (2) supervisory identity and skills sufficient to allow autonomous functioning that is responsible and collegial.

Authorized -- authority given by ACPE for specific persons to serve as primary **supervisor** for a unit of CPE, i.e. **ACPE Supervisor, Associate Supervisor, or National Association of Catholic Chaplains Supervisor** in a center dually accredited by the U.S. Catholic Conference and ACPE. A **Supervisory Candidate** may only supervise under the **supervision** of an **ACPE Supervisor** and may sign students' evaluations in conjunction with the **supervisor**, but may not sign the **ACPE student unit report form**.

Certification -- action by the **ACPE Certification Commission** to grant the time-limited status of **Supervisory Candidate** or **Associate Supervisor** or the status of **ACPE Supervisor** to persons affirmed in a review as having satisfied **ACPE standards** for the respective status.

Clinical method of learning -- an educational model that uses data from the actual practice of ministry as the content for reflection.

Clinical Pastoral Education (CPE; clinical education, clinical pastoral learning) -- a method of learning ministry by means of pastoral functioning under **supervision** as developed by ACPE. It is a **process model of education**, predicated on **students'** individual needs that are compatible with program objectives. ACPE distinguishes two types of CPE programming: **CPE (Level I /Level II)** and **Supervisory CPE**.

Commission -- a **representative group** given authority to make decisions on behalf of ACPE.

Complaint -- a **grievance**, presented in writing and signed, involving an alleged violation of the ethical criteria established by **ACPE Standards 100 Code of Professional Ethics**. A **complaint** must identify the specific **standard** alleged to have been violated.

Component -- one of the structured elements that comprise a **CPE program**.

Consultation -- a meeting of persons in which an individual or group seeks feedback and non-binding advice about functioning, progress and/or plans in CPE.

Contract for learning -- an agreement developed cooperatively by a **student** and **CPE supervisor** which establishes the learning goals of the **student** and the means to achieve those goals in a **unit of CPE**.

CPE Level I -- a program consisting of CPE unit(s) in which the **student** focuses on meeting the outcomes established in **ACPE Standard 311**.

CPE Level II -- a program consisting of CPE unit(s) in which the **student** focuses on meeting the outcomes established in **ACPE Standard 312**.

CPE program(s) -- structured system of **components** (e.g., **supervisor, curriculum, clerical services, consultants, student peer group, experiences in ministry to clients,**

multi-disciplinary personnel, evaluation process, specific time frames, learning contract, etc.) in which clinical pastoral learning can occur and is accredited by ACPE.

Cultural humility -- an attitude of respect when approaching people of different cultures, which entails engagement in a process of self-reflection and self-critique requiring an ability to move beyond one's own biases.

Culture -- A symbolic system of meanings, attitudes, feelings, values and behaviors that is shared by a group of people, a particular society or population, and is communicated from one generation to the next via language and/or observation. **Culture** regulates and organizes what a group feels, thinks or does, but may be expressed individually in a variety of ways. **Culture** includes: familial roles, patterns of social and interpersonal communication, affective styles, values and ideals, spirituality and religion, habits of thinking and artistic expressions, customs and norms, rituals and celebrations, and geographical and historical location.

Curriculum -- the total educational program of CPE, including its methodology (program components, i.e., conceptual/didactic sessions, ministry practice, clinical critique, seminar types, written materials, bibliography, other creative experiences, etc.), appropriate to the center's **CPE programs**.

Educational guidance -- timely provision of, or referral to, educational resources appropriate to the needs of the student in addressing the student's goals or the objectives and outcomes of the **CPE program**.

Ethnic Identity -- refers to people who share a common nationality, culture or language. Race refers to differences due to observable physical features, such as skin color, hair type and color, stature, head shape and size, and other facial features. Both are socio-cultural constructs, defined communally and contextually.

Faculty -- person(s) employed or contracted by the **ACPE center** to provide clinical instruction and/or direct **supervision** of students' pastoral or **supervisory** formation and function. A faculty member must be certified as **ACPE Supervisor, Associate Supervisor** or **Supervisory Candidate**. A **Supervisory Candidate** functioning as a clinical educator must work under the **supervision** of a person with current credentials as **ACPE Supervisor**. In a center dually accredited by the U.S. Catholic Conference and ACPE, a National Association of Catholic Chaplains **Supervisor** may be a **faculty member**.

Faith group endorsement -- formal recognition by a faith group that a person is a member in good standing of that group and affirmation of that person for **admission** to the status of **Supervisory Candidate** and/or certification as **Associate Supervisor** or **ACPE Supervisor**.

Grievance -- an alleged violation of ethical/and or professional conduct believed to afford reason for a **complaint**. (See definition of **complaint**.)

Impairment -- state of reduced professional functioning wherein a practitioner fails to provide safe, ethical, competent service due to organic illness, excessive use of alcohol and/or drugs, stress related disorder, mental or emotional disability, or deterioration through the aging process.

Master of Divinity degree or equivalent -- graduation from an accredited theological school with a Master of Divinity degree; or ordination from a recognized Jewish seminary; or three academic years of full-time (or equivalent part-time) post-baccalaureate accredited, theological education; or a post-baccalaureate theological degree with such additional study and vocational formation experience as may be evaluated by an appropriate ACPE regional **certification** committee to constitute equivalent level of study; or a Master's degree in a related field with such additional post-baccalaureate theological course work and vocational formation experience as may be evaluated by an appropriate ACPE regional **certification** committee to constitute an equivalent level of study.

Member -- for purposes of the ACPE Standards, individuals holding the class/type of membership in ACPE as **ACPE Supervisor, Associate Supervisor, Supervisory Candidate, Supervisor on Leave, Retired Supervisor, Clinical Member, Student Affiliate Member, and Retired Member** as defined in the ACPE Bylaws.

Multicultural -- a society made up of peoples of many cultures, in which there is cross-cultural interaction and intercultural engagement.

Pastoral Competence -- the discovery and use of skills necessary for the intensive and extensive practice of ministry.

Pastoral Formation -- the exploration and development of one's pastoral identity and practice through integrating one's heritage, theology and knowledge of behavioral and social sciences.

Pastoral Reflection -- the process of increasing awareness and understanding of, and ability to articulate, the meaning and purpose of one's experience in ministry.

Pastoral Specialization -- development of **pastoral competence** in an area of ministry with an identified focus in a particular setting or context.

Peer group -- small group of at least three **CPE (Level I/II) students** engaged in small group process and committed to fulfilling the requirements of the educational program.

Policy -- a set of rules and/or directions on a designated subject, congruent with ACPE standards, procedures and guidelines, by which decisions are made.

Procedure -- a set of steps to be followed in a regular and definite order to accomplish a designated purpose. **Procedures for accreditation of centers, certification of**

supervisors, and dealing with **complaints** of ethics code violations can be found in the respective manuals, available from ACPE or at www.acpe.edu.

Process model of education -- an understanding of growth and change (in behavior, beliefs, ideas, awareness, etc.) as taking place gradually or in on-going modifications, and as never being finished or perfected.

Professional advisory group (professional **consultation** group, committee, etc.) -- group of interdisciplinary professional resource persons used by the **ACPE center** at regular intervals over time to provide advice and **consultation** on center and program planning, development and program evaluation. **Members** of this group are qualified in their fields and knowledgeable about CPE.

Program unit -- a unit of CPE, as defined in ACPE standard 308.1. The **curriculum** of a program unit is at least 100 contact hours of structured group and individual education. Each unit shall be accompanied by the supervised clinical practice in ministry. The combined time shall be no less than 400 hours.

Qualified interviewer -- **ACPE supervisor** or other person meeting these criteria:

- knowledgeable about current **ACPE standards, procedures, practices, and objectives,**
- objective as to the interests of the applicant, church, seminary, center, and CPE,
- able to recognize those qualities of well being, personality and faith which will enable an applicant to develop in CPE,
- able to dynamically engage the applicant and assess readiness for CPE,
- able to assess the applicant's potential to benefit from CPE in the center(s) to which application is being made,

and who may prepare an **admission interview** report that becomes part of the applicant's CPE application.

Reciprocity -- mutual exchange of the status of **certification** of CPE **supervisors** as **authorized** by the ACPE Board of Representatives.

Representative -- person appointed, elected or employed, who serves in an ACPE regional or national office or **position** or chairs a committee or **commission**.

Sexual exploitation -- any sexual advance, request for sexual favors, or physical contact of a sexual nature, even if by mutual consent, between persons in situations of unequal power. **Sexual exploitation** is inclusive of the terms sexual harassment, sexual abuse and sexual misconduct. Sexual contact with those served pastorally or supervised, even if by consent, is considered a violation of the ACPE Code of Professional Ethics.

Social location -- a person's position in the world in relation to accessing resources; location is in reference to social groups; complex arrangements determined by economics, class structure, **culture**, etc.

Standards-- adequate and relevant parameters of educational quality that define and advance practice and provide a framework for evaluation.

Student -- person admitted to and participating in a program of CPE.

Student record -- confidential file maintained by a CPE center that may contain admissions material, reports, evaluations, individual **contract for learning**, and other material related to a student's CPE experience. (See ACPE *Accreditation Manual*, Appendix 12 *Guidelines for Student Records*.)

Supervision (CPE supervision, pastoral supervision) -- an educational method by which a supervisor, through a face-to-face relationship, enables students to learn about self, others, the spiritual, and ministry from clinical experience and examination of that experience so that students integrate their learning in their professional identity and functioning.

Supervisor -- a clinical pastoral educator who satisfies ACPE requirements for certification, either an ACPE Supervisor or Associate Supervisor.

Supervisory Candidate -- an admission status into the certification process granted to students in Supervisory CPE who demonstrate readiness to supervise students in programs of CPE under the supervision of a person with current credentials as an ACPE Supervisor; may supervise students under supervision, but without direct observation, as further supervisory competence is gained.

Types of CPE programs -- CPE (Level 1/Level II) and Supervisory CPE, with standards, objectives and admission requirements specific to each type.

PART FOUR -- APPENDICES

APPENDIX 1 Accountability For Ethical Conduct Policy Report Form

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APPENDIX 1

**ACCOUNTABILITY FOR ETHICAL CONDUCT POLICY
REPORT FORM**

For the purposes of this Policy, "member" refers to: ACPE Supervisors, Associate Supervisors, Active Retired Supervisors, Supervisory Candidates, and Clinical Members.

I certify that (a) no discipline or corrective action arising from a **complaint** of unethical or felonious conduct has been imposed on me, and no **complaint** against me for unethical or felonious conduct is pending in a civil, criminal, ecclesiastical, employment or another professional organization's forum; and, (b) I have never resigned, been transferred or terminated, nor negotiated a settlement from a position for reasons related to unethical or felonious conduct.

Date _____ / _____ / _____

Signature _____

If the above cannot be certified, please provide an account of the **complaint** including the forum, the charges, and the final outcome. Provide the names of people involved in the process whom you authorize to provide full information to ACPE representatives. **Prior actions are not an automatic bar to ACPE membership. Each situation will be evaluated on its own merits by an Accountability Review Committee composed of the Executive Director, the Chair of the Professional Ethics Commission (PEC), the Chair of the Certification Commission, the PEC legal consultant, and a designated Board member.** ACPE has the right to extend or deny candidacy status or membership regardless of previous **complaints**, other forum's findings or subsequent remedial actions according to the judgment of the named **representatives** to the Accountability Review Committee on behalf of the Association. If denied, the applicant may resubmit an application at a later time. Decisions are final and binding on ACPE. *(Attach pages if necessary.)*

I understand that as a condition of membership in the Association for **Clinical Pastoral Education** I will provide to the Association timely notice of any **complaint** of unethical or felonious conduct filed against me. I agree to provide to the ACPE Professional Ethics **Commission** in a timely fashion the information it requests regarding the investigation, adjudication, dismissal or settlement of such **complaint**. Failure to report or provide accurate, full and truthful information may be grounds for discipline including removal of membership in the Association for **Clinical Pastoral Education, Inc.**

Date _____ / _____ / _____

Signature _____

Printed Name _____

Current Membership Category _____

Comments for CMS-3844-P

**Medicare and Medicaid Programs:
Hospice Conditions of Participation**

July 13, 2005

“II. Background (pg 30840)

A. The Medicare Hospice Benefit

Hospice care is an approach to caring for the terminally ill individual that provides palliative care rather than traditional medical care and curative treatment. Palliative care is treatment for the relief of pain and other uncomfortable symptoms through the appropriate coordination of all aspects of care needed to maximize personal comfort and relieve distress. **Hospice care allows the patient to remain at home as long as possible by providing support to the patient and family, and keeping the patient as comfortable as possible while maintaining his or her dignity and quality of life.**” (Proposed Hospice Conditions of Participation as published on May 27, 2005)

This explanation of the hospice benefit is designed to set the framework that the rest of the legislation is to build upon. The emphasis placed on patient comfort and dignity resonates through out the entirety of the Conditions of Participation with the exception of the way that outside staffing is handled when dealing with continuous care.

“We believe that the new MMA provision authorizes us to propose that hospices may not routinely contract for a specific level of care (e.g., continuous care) or for specific hours of care (e.g., evenings and week-ends), as these are regularly occurring situations that hospices are able to plan staffing for.” Pg 30850

Unfortunately the authors of this passage are incorrect about a hospice’s ability to “plan staffing for” continuous care for two main reasons.

Continuous Care Patient Census are Extremely Unstable

According to previous regulations continuous care is only to be given to patients in crisis that need eight or more hours of nursing care per day to be maintained at home. By their very definition continuous care patients are critical unstable patients. It has been our experience that continuous care patients survive an average of three to four days before passing on, and have the habit of going into a periods of crisis which necessitates continuous care at very inconvenient times for their hospice provider. Hence, **Continuous Care Patient Census Are Not Stable and Are Not Predictable**. A hospice can literally have 6 continuous care patients on Friday, 10 by Saturday, and 3 by Tuesday. Exactly how is a hospice supposed to plan staffing for continuous care patients if they cannot predict how many continuous care patients they are going to have?

Continuous Care Shifts are Generally 12 Hour Shifts

In order to maintain consistency of staff with a patient and their family that is facing immanent death, Continuous Care Shifts normally last 12 hours. In contrast the average routine visit lasts a little longer than an hour making it easy for a hospice to request a staff member to take on an

extra routine visit when the hospice is running short on staff. Obviously it is not possible to request a staff member to take on an extra 12 hour continuous care shifts on top of their previously scheduled routine care visits.

If a hospice is going to "provide support to the patient and family, and keep the patient as comfortable as possible while maintaining his or her dignity and quality of life", they need to be allowed to use any experienced qualified nurses they can find, otherwise you are holding them to a standard that is impossible to live up to unless they use the tools (staffing agencies) that you have forbidden them to use. If the reason for this restriction on the use of staffing agencies stems from anxiety regarding the quality of staff provided by staffing agency than why include the following in the conditions of participation?

"As with all other contracting arrangements, the hospice would be required to maintain professional management responsibility for the service(s) being provided under arrangement as well as the individual(s) providing them. " pg3085

If there is still a question of the quality of care provided by staffing agencies who care for hospice patients, the answer to ensuring quality of patient care is not banning legitimate and needed uses of outside agency such as in the realm of continuous care, but instead overseeing them. Why not survey staffing agencies for the right to see hospice patients? If the staffing agency is enforcing the standards set for in the conditions of participation than your anxieties are eased with a survey, if a staffing agency is not living up to those standards than they can be forced to shape up or stop seeing hospice patients. Either way quality of care for hospice patients is improved and more patients gain access to the care that they need.

"The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of terminal illness.

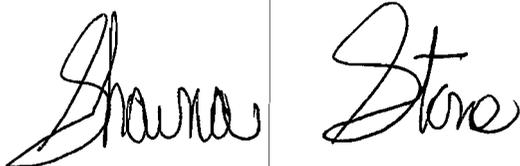
(a) Standard: Serving the hospice patient and family. The hospice must ensure--

- (1) That each patient receives and experiences hospice care that optimizes comfort and dignity; and*
- (2) That each patient experience hospice care that is consistent with patient and family needs and desires." (Sec 418.100)*

Unfortunately nurses do not take turns being sick or having family emergencies, and patients do not wait their turn to enter into a period of crisis. If you truly want a hospice to live up to the standards quoted above for all their patients, continuous care patients included, you must find a way to allow hospices access to the quality nurses that they need when they are short on staff, otherwise those standards are simply unobtainable.

Thank you for your time.

Shauna L. Stone

The image shows two handwritten signatures of Shauna L. Stone. The signature on the left is a cursive script, and the signature on the right is a more stylized, blocky cursive script.