

for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.

(2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.

§ 418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services.

The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient. The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.

(a) *Standard: Approach to service delivery.* (1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:

(i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice).

(ii) A registered nurse.

(iii) A social worker.

(iv) A pastoral or other counselor.

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

(b) *Standard: Plan of care.* All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

(c) *Standard: Content of the plan of care.* The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

(1) Interventions to manage pain and symptoms.

(2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.

(3) Measurable outcomes anticipated from implementing and coordinating the plan of care.

(4) Drugs and treatment necessary to meet the needs of the patient.

(5) Medical supplies and appliances necessary to meet the needs of the patient.

(6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the

plan of care, in accordance with the hospice’s own policies, in the clinical record.

(d) *Standard: Review of the plan of care.* The hospice interdisciplinary group (in collaboration with the individual’s attending physician, if any) must review, revise and document the individualized plan as frequently as the patient’s condition requires, but no less frequently than every 15 calendar days. A revised plan of care must include information from the patient’s updated comprehensive assessment and must note the patient’s progress toward outcomes and goals specified in the plan of care.

(e) *Standard: Coordination of services.* The hospice must develop and maintain a system of communication and integration, in accordance with the hospice’s own policies and procedures, to—

(1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided.

(2) Ensure that the care and services are provided in accordance with the plan of care.

(3) Ensure that the care and services provided are based on all assessments of the patient and family needs.

(4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.

(5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.

§ 418.58 Condition of participation: Quality assessment and performance improvement.

The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice’s governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes

actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

(a) *Standard: Program scope.* (1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.

(2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.

(b) *Standard: Program data.* (1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.

(2) The hospice must use the data collected to do the following:

(i) Monitor the effectiveness and safety of services and quality of care.

(ii) Identify opportunities and priorities for improvement.

(3) The frequency and detail of the data collection must be approved by the hospice’s governing body.

(c) *Standard: Program activities.* (1) The hospice’s performance improvement activities must:

(i) Focus on high risk, high volume, or problem-prone areas.

(ii) Consider incidence, prevalence, and severity of problems in those areas.

(iii) Affect palliative outcomes, patient safety, and quality of care.

(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.

(3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.

(d) *Standard: Performance improvement projects.* Beginning February 2, 2009 hospices must develop, implement, and evaluate performance improvement projects.