

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.

[73 FR 32204, June 5, 2008, as amended at 88 FR 79539, Nov. 16, 2023]

**§ 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: