



Side by Side: Medicare Hospice Conditions of Participation v. Iowa Law

2008 FINAL MEDICARE CONDITIONS OF PARTICIPATION	<i>Iowa Law</i>
<p>§ 418.2 Scope of the part. This part establishes requirements and the conditions of participation that hospices must meet, and be in compliance with, in order to participate in the Medicare program. Subpart A of this part sets forth the statutory basis and scope and defines terms used in this part. Subpart B of this part specifies the eligibility requirements and the benefit periods. Subpart C of this part specifies the conditions of participation that hospice providers must meet regarding patient and family care. Subpart D of this part specifies the organizational environment that hospice providers must meet as conditions of participation. Subpart E is reserved for future use. Subpart F specifies coinsurance amounts applicable to hospice care.</p>	
<p>§ 418.3 Definitions For the purposes of this part—</p> <p><i>Bereavement counseling</i> means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjusting.</p> <p><i>Cap period</i> means the 12-month period ending October 31 used in the application of the cap on overall hospice reimbursement specified in §418.309.</p> <p><i>Clinical note</i> means a notation of a</p>	<p><i>*"Bereavement service"</i> is support offered during the bereavement period to the family and friends of someone who has died. (481 I.A.C. 53.1)</p>

This document is a best effort by IHO to identify the relevant state laws necessary for comparison to the Medicare hospice COPs, but IHO makes no warranties that this document contains all pertinent provisions of Iowa law. (last amended 10-17-08)

*This provision only applies if the hospice is licensed in Iowa under Iowa Code chapter 135J, which is currently optional.

contact with the patient and/or the family that is written and dated by any person providing services and that describes signs and symptoms, treatments and medications administered, including the patient's reaction and/or response, and any changes in physical, emotional, psychosocial or spiritual condition during a given period of time.

Comprehensive assessment means a thorough evaluation of the patient's physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions. This includes a thorough evaluation of the caregiver's and family's willingness and capability to care for the patient.

Dietary counseling means education and interventions provided to the patient and family regarding appropriate nutritional intake as the patient's condition progresses. Dietary counseling is provided by qualified individuals, which may include a registered nurse, dietitian or nutritionist, when identified in the patient's plan of care.

Employee means a person who works for the hospice and for whom the hospice is required to issue a W-2 form on his or her behalf, or if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice or is a volunteer under the jurisdiction of the hospice.

Hospice means a public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care as defined in this section.

Initial assessment means an evaluation of the patient's physical, psychosocial and emotional status related to the terminal illness and related conditions to determine the patient's immediate care and support needs.

***"Family"** means the immediate kin of the patient, including a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, child, or stepchild. Additional relatives or individuals with significant personal ties to the hospice patient may be included in the hospice patient's family. (481 I.A.C. 53.1)

Licensed professional means a person licensed to provide patient care services by the State in which services are delivered.

Palliative care means patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

Physician means an individual who meets the qualifications and conditions as defined in section 1861 (r) of the Act and implemented at §410.20 of this chapter.

Physician designee means a doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available.

Representative means an individual who has the authority under State law (whether by statute or pursuant to an appointment by the courts of the State) to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill patient who is mentally or physically incapacitated. This may include a legal guardian.

Restraint means—

(1) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of

***"Hospice program"** means a centrally coordinated program of home and inpatient care provided directly or through an agreement under the direction of an identifiable hospice administration providing palliative care and supportive medical and other health services to terminally ill patients and their families. A licensed hospice program shall utilize a medically directed interdisciplinary team and provide care to meet the physical, emotional, social, spiritual, and other special needs which are experienced during the final stages of illness, dying, and bereavement. Hospice care shall be available twenty-four hours a day, seven days a week. (Iowa Code § 135J.1(5))

***"Palliative care"** means care directed at managing symptoms experienced by the hospice patient, as well as addressing related needs of the patient and family as they experience the stress of the dying process. The intent of palliative care is to enhance the quality of life for the hospice patient and family unit, and is not treatment directed at cure of the terminal illness. (Iowa Code § 135J.1(6))

<p>bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort); or (2) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.</p> <p>Multiple location means a Medicare approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice issued the certification number. A multiple location must meet all of the conditions of participation applicable to hospices.</p> <p>Seclusion means the involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving.</p> <p>Terminally ill means that the patient has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.</p>	
<p>Subpart B – Eligibility, Election and Duration of Benefits Changes to Subparts B, F, and G were published as a final rule on November 22, 2005 with an implementation date of January 23, 2006.</p>	<p>441 I.A.C. 78.36 Hospice services. (Medicaid Hospice Eligibility, Election Requirements)</p>
<p>Subpart C – Conditions of Participation: General Provisions & Administration</p>	
<p>§ 418.52 Condition of participation: Patient's rights. The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights. (a) Standard: Notice of rights and responsibilities. (1) During the initial assessment visit in advance of furnishing care the hospice must provide the patient or representative with verbal (meaning</p>	<p>*481 I.A.C. 53.3 Patient rights. Each hospice program shall have written policies and procedures that support, enhance and protect the human, civil, constitutional and statutory rights of all patients. 53.3(1) Patient rights include, but are not limited to, the right to: <i>a.</i> Be treated with dignity and respect; <i>b.</i> Be informed of the type of care and the services provided by the hospice program;</p>

<p>spoken) and written notice of the patient's rights and responsibilities in a language and manner that the patient understands.</p> <p>(2) The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law.</p> <p>(3) The hospice must obtain the patient's or representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.</p> <p>(b) Standard: Exercise of rights and respect for property and person.</p> <p>(1) The patient has the right:</p> <p>(i) To exercise his or her rights as a patient of the hospice;</p> <p>(ii) To have his or her property and person treated with respect;</p> <p>(iii) To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and</p> <p>(iv) To not be subjected to discrimination or reprisal for exercising his or her rights.</p> <p>(2) If a patient has been adjudged incompetent under state law by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed pursuant to state law to act on the patient's behalf.</p> <p>(3) If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.</p> <p>(4) The hospice must:</p> <p>(i) Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice</p>	<p>c. Information regarding diagnosis and prognosis and any change in either;</p> <p>d. Review and participate in their plan of care; and</p> <p>e. Privacy.</p> <p>53.3(2) A copy of these rights shall be provided to all individuals admitted to a hospice.</p> <p>This rule is intended to implement Iowa Code section 135J.3(3).</p> <p>Reports of Abuse:</p> <p>Child Abuse Reports (Iowa Code 232.69, .70)</p> <p>232.69 MANDATORY AND PERMISSIVE REPORTERS -- TRAINING REQUIRED.</p> <p>1. The classes of persons enumerated in this subsection shall make a report within twenty-four hours and as provided in section 232.70, of cases of child abuse. In addition, the classes of persons enumerated in this subsection shall make a report of abuse of a child who is under twelve years of age and may make a report of abuse of a child who is twelve years of age or older, which would be defined as child abuse under section 232.68, subsection 2, paragraph "c" or "e", except that the abuse resulted from the acts or omissions of a person other than a person responsible for the care of the child.</p> <p>a. Every health practitioner who in the scope of professional practice, examines, attends, or treats a child and who reasonably believes the child has been abused. Notwithstanding section 139A.30, this provision applies to a health practitioner who receives information confirming that a child is infected with a sexually transmitted disease.</p> <p>b. Any of the following persons who, in the scope of professional practice or in their employment responsibilities, examines, attends, counsels, or treats a child and reasonably believes a child has</p>
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<p>administrator;</p> <p>(ii) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures;</p> <p>(iii) Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency; and</p> <p>(iv) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation.</p> <p>(c) Standard: Rights of the patient. The patient has a right to the following:</p> <p>(1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness;</p> <p>(2) Be involved in developing his or her hospice plan of care;</p> <p>(3) Refuse care or treatment;</p> <p>(4) Choose his or her attending physician;</p> <p>(5) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.</p> <p>(6) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property;</p> <p>(7) Receive information about the services covered under the hospice benefit;</p> <p>(8) Receive information about the scope of services that the hospice will provide and specific limitations on those services.</p>	<p>suffered abuse:</p> <p>(1) A social worker.</p> <p>(2) An employee or operator of a public or private health care facility as defined in section 135C.1.</p> <p>(3) A certified psychologist.</p> <p>(4) A licensed school employee, certified para-educator, holder of a coaching authorization issued under section 272.31, or an instructor employed by a community college.</p> <p>(5) An employee or operator of a licensed child care center, registered child development home, head start program, family development and self-sufficiency grant program under section 217.12, or healthy opportunities for parents to experience success—healthy families Iowa program under section 135.106.</p> <p>(6) An employee or operator of a substance abuse program or facility licensed under chapter 125.</p> <p>(7) An employee of a department of human services institution listed in section 218.1.</p> <p>(8) An employee or operator of a juvenile detention or juvenile shelter care facility approved under section 232.142.</p> <p>(9) An employee or operator of a foster care facility licensed or approved under chapter 237.</p> <p>(10) An employee or operator of a mental health center.</p> <p>(11) A peace officer.</p> <p>(12) A counselor or mental health professional.</p> <p>(13) An employee or operator of a provider of services to children funded under a federally approved medical assistance home and community-based services waiver.</p> <p>2. Any other person who believes that a child has been abused may make a report as provided in section 232.70.</p> <p>3. a. For the purposes of this subsection, "licensing board" means a board designated in section 147.13, the board of educational examiners created in section 272.2, or a licensing board as defined in section 272C.1.</p> <p>b. A person required to make a</p>
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	<p>report under subsection 1, other than a physician whose professional practice does not regularly involve providing primary health care to children, shall complete two hours of training relating to the identification and reporting of child abuse within six months of initial employment or self-employment involving the examination, attending, counseling, or treatment of children on a regular basis. Within one month of initial employment or self-employment, the person shall obtain a statement of the abuse reporting requirements from the person's employer or, if self-employed, from the department. The person shall complete at least two hours of additional child abuse identification and reporting training every five years.</p> <p>c. If the person is an employee of a hospital or similar institution, or of a public or private institution, agency, or facility, the employer shall be responsible for providing the child abuse identification and reporting training. If the person is self-employed, employed in a licensed or certified profession, or employed by a facility or program that is subject to licensure, regulation, or approval by a state agency, the person shall obtain the child abuse identification and reporting training as provided in paragraph "d".</p> <p>232.70 REPORTING PROCEDURE.</p> <p>1. Each report made by a mandatory reporter, as defined in section 232.69, subsection 1, shall be made both orally and in writing. Each report made by a permissive reporter, as defined in section 232.69, subsection 2, may be oral, written, or both.</p> <p>2. The employer or supervisor of a person who is a mandatory or permissive reporter shall not apply a policy, work rule, or other requirement that interferes with the person making a report of child abuse.</p> <p>3. The oral report shall be made by telephone or otherwise to the department of human services. If the person making the report has reason to believe that immediate protection for the child is advisable, that person shall also</p>
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	<p>make an oral report to an appropriate law enforcement agency.</p> <p>4. The written report shall be made to the department of human services within forty-eight hours after such oral report.</p> <p>5. Upon receipt of a report the department shall do all of the following:</p> <ul style="list-style-type: none">a. Immediately, upon receipt of an oral report, make a determination as to whether the report constitutes an allegation of child abuse as defined in section 232.68.b. Notify the appropriate county attorney of the receipt of the report. <p>6. The oral and written reports shall contain the following information, or as much thereof as the person making the report is able to furnish:</p> <ul style="list-style-type: none">a. The names and home address of the child and the child's parents or other persons believed to be responsible for the child's care;b. The child's present whereabouts if not the same as the parent's or other person's home address;c. The child's age;d. The nature and extent of the child's injuries, including any evidence of previous injuries;e. The name, age and condition of other children in the same home;f. Any other information which the person making the report believes might be helpful in establishing the cause of the injury to the child, the identity of the person or persons responsible for the injury, or in providing assistance to the child; andg. The name and address of the person making the report. <p>7. A report made by a permissive reporter, as defined in section 232.69, subsection 2, shall be regarded as a report pursuant to this chapter whether or not the report contains all of the information required by this section and may be made to the department of human services, county attorney, or law enforcement agency. If the report is made to any agency other than the department of human services,</p>
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such agency shall promptly refer the report to the department of human services.

8. If a report would be determined to constitute an allegation of child abuse as defined under section 232.68, subsection 2, paragraph "c" or "e", except that the suspected abuse resulted from the acts or omissions of a person other than a person responsible for the care of the child, the department shall refer the report to the appropriate law enforcement agency having jurisdiction to investigate the allegation. The department shall refer the report orally as soon as practicable and in writing within seventy-two hours of receiving the report.

9. Within twenty-four hours of receiving a report from a mandatory or permissive reporter, the department shall inform the reporter, orally or by other appropriate means, whether or not the department has commenced an assessment of the allegation in the report.

Dependent Adult Abuse Reporting in Community Based Setting or Hospice House Iowa Code 235B.3

2. A person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse, shall report the suspected dependent adult abuse to the department. Persons required to report include all of the following:

a. A member of the staff of a community mental health center, a member of the staff of a hospital, a member of the staff or employee of a public or private health care facility as defined in section 135C.1, a member of the staff or employee of an elder group home as defined in section 231B.1, a member of the staff or employee of an assisted living program certified under section 231C.3, and a member of the staff or employee of an adult day services program as defined in section 231D.1.

- b.* A peace officer.
- c.* An in-home homemaker-home health aide.
- d.* An individual employed as an outreach person.
- e.* A health practitioner, as defined in section 232.68.
- f.* A member of the staff or an employee of a supported community living service, sheltered workshop, or work activity center.
- g.* A social worker.
- h.* A certified psychologist.

3. *a.* If a staff member or employee is required to report pursuant to this section, the person shall immediately notify the department and shall also immediately notify the person in charge or the person's designated agent.

b. The employer or supervisor of a person who is required to or may make a report pursuant to this section shall not apply a policy, work rule, or other requirement that interferes with the person making a report of dependent adult abuse or that results in the failure of another person to make the report.

Dependent Adult Abuse Reports in a Facility Setting (nursing home, hospital, assisted living, or elder group home) 235E.2

2. A staff member or employee of a facility or program who, in the course of employment, examines, attends, counsels, or treats a dependent adult in a facility or program and reasonably believes the dependent adult has suffered dependent adult abuse, shall report the suspected dependent adult abuse to the department.

3. *a.* If a staff member or employee is required to make a report pursuant to this section, the staff member or employee shall immediately notify the person in charge or the person's designated agent who shall then notify the department within twenty-four hours of such notification. If the person in charge is the alleged dependent adult abuser, the staff member shall directly

report the abuse to the department within twenty-four hours.

b. The employer or supervisor of a person who is required to or may make a report pursuant to this section shall not apply a policy, work rule, or other requirement that interferes with the person making a report of dependent adult abuse or that results in the failure of another person to make the report.

441 I.A.C. 79.12 Advance directives.

“Advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1)

A hospital at the time of a person’s admission as an inpatient, a home health care provider in advance of a person’s coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person’s rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider’s policies regarding the implementation of these rights.

79.12(2)

The provider or organization shall document in the person’s medical record whether or not the person has executed an advance directive.

79.12(3)

	<p>The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.</p> <p>79.12(4)</p> <p>The provider or organization shall ensure compliance with requirements of state law regarding advance directives.</p> <p>79.12(5)</p> <p>The provider or organization shall provide for education for staff and the community on issues concerning advance directives.</p> <p>Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.</p> <p>This rule is intended to implement Iowa Code section 249A.4.</p>
<p>§ 418.54 Condition of participation: Initial and comprehensive assessment of the patient.</p> <p>The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient’s need for hospice care and services, and the patient’s need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.</p> <p>(a) Standard: Initial assessment. The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with § 418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)</p> <p>(b) Standard: Timeframe for completion of the comprehensive assessment. The hospice interdisciplinary group, in consultation with the individual’s attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of</p>	

hospice care in accordance with § 418.24.

(c) Standard: Content of the comprehensive assessment. The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following factors:

- (1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).
- (2) Complications and risk factors that affect care planning.
- (3) Functional status, including the patient's ability to understand and participate in his or her own care.
- (4) Imminence of death.
- (5) Severity of symptoms.
- (6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:
 - (i) Effectiveness of drug therapy.
 - (ii) Drug side effects.
 - (iii) Actual or potential drug interactions.
 - (iv) Duplicate drug therapy.
 - (v) Drug therapy currently associated with laboratory monitoring.
- (7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.
- (8) The need for referrals and further evaluation by appropriate health professionals.

(d) Standard: Update of the comprehensive assessment. The update of the comprehensive assessment must be accomplished by the

<p>hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.</p> <p>(e) Standard: Patient outcome measures.</p> <p>(1) The comprehensive assessment must include data elements that allow 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.</p> <p>(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.</p>	
<p>§ 418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services.</p> <p>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.</p> <p>(a) Standard: Approach to service delivery.</p> <p>(1) The hospice must designate an interdisciplinary group or groups</p>	<p><i>"Interdisciplinary team"</i> means the hospice patient and the hospice patient's family, the attending physician, and all of the following individuals trained to serve with a licensed hospice program:</p> <ul style="list-style-type: none"> <i>a.</i> A licensed physician pursuant to chapter 148, 150, or 150A. <i>b.</i> A licensed registered nurse pursuant to chapter 152. <i>c.</i> An individual with at least a baccalaureate degree in the field of social work providing medical-social services. <i>d.</i> Trained hospice volunteers. <p>Providers of special services, including but not limited to, a spiritual counselor, a pharmacist, or professionals in the fields of mental health may be included on the interdisciplinary team as deemed appropriate by the hospice. (Iowa Code § 135J.1(6))</p>

<p>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:</p> <ul style="list-style-type: none"> (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. <p>(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.</p> <p>(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.</p> <p>(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</p>	<p>*481—53.8 Interdisciplinary team (IDT). The IDT shall establish a plan of care for each patient and family based on assessments performed by team members.</p> <p>53.8(1) The interdisciplinary team shall include the:</p> <ul style="list-style-type: none"> a. Patient; b. Hospice patient's family; c. Attending physician; d. Medical director; e. Patient care coordinator; f. Staff nurse; g. Social worker; h. Coordinator of volunteer service; and may include i. A spiritual counselor and others deemed appropriate by the hospice. <p>53.8(2) Prior to or on the day of admission, the attending physician and at least one IDT team member shall develop an initial plan based on a preliminary assessment of the patient and family needs.</p> <p>53.8(3) Within seven calendar days of admission the interdisciplinary team shall assess the needs of the patient and family. A care plan shall be based on these findings.</p> <p>53.8(4) Within seven calendar days of admission the interdisciplinary team shall meet to develop a comprehensive written plan of care. The plan of care shall:</p> <ul style="list-style-type: none"> a. Identify the primary caregiver or an alternate arrangement for care; b. List the needs of the patient and family; c. List any intervention planned to meet the needs of the patient and family and the results expected from each intervention; d. Indicate which team member(s) is responsible for each intervention; e. Indicate the anticipated frequency of each intervention; and f. Indicate the prognosis and expected disease process. <p>53.8(5) The IDT shall monitor and revise the plan of care on a regular basis. The team shall meet weekly and exchange information regarding the needs of the patient and family. Changes</p>
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<p>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:</p> <ol style="list-style-type: none"> (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. <p>(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.</p> <p>(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—</p> <ol style="list-style-type: none"> (1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising 	<p>in the care plan shall be made when the needs of the patient or family change or when interventions do not result in the expected or intended response. This rule is intended to implement Iowa Code section 135J.3(5).</p> <p>*481 I.A.C. 53.11 Coordinator of patient care. A registered nurse, social worker or health care administrator shall be designated to coordinate implementation of the plan of care for each patient. The coordinator of patient care shall at least:</p> <ol style="list-style-type: none"> 1. Coordinate all aspects of patient care to ensure continuity, including care by all service disciplines in all care settings; 2. Facilitate exchange of information among all personnel who provide services to ensure complementary efforts and support for objectives outlined in the plan of care; 3. Facilitate communication between caregivers, patient and family; 4. Maintain a roster of patients; 5. Maintain a schedule for IDT review of care plans; and 6. Chair IDT conferences. <p>This rule is intended to implement Iowa Code section 135J.3(2).</p>
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<p>the care and services provided.</p> <p>(2) Ensure that the care and services are provided in accordance with the plan of care.</p> <p>(3) Ensure that the care and services provided are based on all assessments of the patient and family needs.</p> <p>(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.</p> <p>(5) Provide for an ongoing sharing of information with other non-hospice health care providers furnishing services unrelated to the terminal illness and related conditions.</p>	
<p>§ 418.58 Condition of participation: Quality assessment and performance improvement.</p> <p>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.</p> <p>The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.</p> <p>(a) Standard: Program scope.</p> <p>(1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.</p> <p>(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.</p> <p>(b) Standard: Program data.</p>	<p>*481 I.A.C. 53.5 Quality assurance and utilization review.</p> <p>The hospice must have a written procedure for individual assessment of care provided, a process for identifying problems and a system to report findings and recommendations for improving the quality of care delivered to the governing body.</p> <p>53.5(1) At least quarterly, the medical director, patient coordinator and social worker used by the hospice program shall review a minimum of a 10 percent sample of combined active and inactive clinical records of care delivered to hospice patients and families. A written summary shall be prepared for each individual assessment, commenting on the amount and kind of care delivered and including statements addressing any unmet needs.</p> <p>53.5(2) At least quarterly, all summaries of individual assessments shall be reviewed by the people responsible for coordinating quality assurance. A written report will be prepared addressing any identified problems with care, treatment services, availability of services and methods of care delivery.</p> <p>53.5(3) The quality assurance reports shall be made available to the hospice administrator and governing body. The reports shall be reviewed by the governing body at least annually, and the</p>

<p>(1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.</p> <p>(2) The hospice must use the data collected to do the following:</p> <ul style="list-style-type: none"> (i) Monitor the effectiveness and safety of services and quality of care. (ii) Identify opportunities and priorities for improvement. <p>(3) The frequency and detail of the data collection must be approved by the hospice's governing body.</p> <p>(c) Standard: Program activities.</p> <p>(1) The hospice's performance improvement activities must:</p> <ul style="list-style-type: none"> (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. <p>(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.</p> <p>(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.</p> <p>(d) Standard: Performance improvement projects. Beginning February 2, 2009 hospices must develop, implement, and evaluate performance improvement projects.</p> <p>(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.</p> <p>(2) The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.</p> <p>(e) Standard: Executive</p>	<p>review recorded in the governing body's meeting minutes.</p> <p>This rule is intended to implement Iowa Code section 135J.3(8).</p>
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<p>responsibilities. The hospice's governing body is responsible for ensuring the following:</p> <p>(1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.</p> <p>(2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.</p> <p>(3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.</p>	
<p>§ 418.60 Condition of participation: Infection control.</p> <p>The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.</p> <p>(a) Standard: Prevention. The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.</p> <p>(b) Standard: Control. The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that—</p> <p>(1) Is an integral part of the hospice's quality assessment and performance improvement program; and</p> <p>(2) Includes the following:</p> <p>(i) A method of identifying infectious and communicable disease problems; and</p> <p>(ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.</p> <p>(c) Standard: Education. The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.</p>	

<p>§ 418.62 Condition of participation: Licensed professional services.</p> <p>(a) Licensed professional services provided directly or under arrangement must be authorized, delivered, and supervised only by health care professionals who meet the appropriate qualifications specified under § 418.114 and who practice under the hospice's policies and procedures.</p> <p>(b) Licensed professionals must actively participate in the coordination of all aspects of the patient's hospice care, in accordance with current professional standards and practice, including participating in ongoing interdisciplinary comprehensive assessments, developing and evaluating the plan of care, and contributing to patient and family counseling and education; and</p> <p>(c) Licensed professionals must participate in the hospice's quality assessment and performance improvement program and hospice sponsored in-service training.</p>	<p>Iowa Code § 147.2 LICENSE REQUIRED.</p> <p>A person shall not engage in the practice of medicine and surgery, podiatry, osteopathy, osteopathic medicine and surgery, psychology, chiropractic, physical therapy, nursing, dentistry, dental hygiene, optometry, speech pathology, audiology, occupational therapy, respiratory care, pharmacy, cosmetology, barbering, social work, dietetics, marital and family therapy or mental health counseling, massage therapy, mortuary science, athletic training, acupuncture, or sign language interpreting or transliterating, or shall not practice as a physician assistant as defined in the following chapters of this subtitle, unless the person has obtained from the department a license for that purpose.</p> <p>For purposes of this section, a person who is licensed in another state and recognized for licensure in this state pursuant to the nurse licensure compact contained in section 152E.1 or pursuant to the advanced practice registered nurse compact contained in section 152E.3 shall be considered to have obtained a license to practice nursing from the department.</p>
<p>§ 418.64 Condition of participation: Core services.</p> <p>A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section. A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. A hospice may also enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice employee/staff to meet the</p>	<p>*"Core services" means physician services, nursing services, medical social services, counseling services, and volunteer services. These core services, as well as others deemed necessary by the hospice in delivering safe and appropriate care to its case load, can be provided through either direct or indirect arrangement by the hospice. (Iowa Code § 135J.1(1))</p> <p>*481 I.A.C 53.6 (135J) Attending physician services. The patient or family shall designate an attending physician who is responsible for managing necessary medical care. The attending physician shall:</p> <ol style="list-style-type: none"> 1. Have an active Iowa license to practice medicine pursuant to Iowa Code chapter 148, 150 or 150A; 2. Certify in conjunction with the medical director that each person requesting

<p>needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include: Unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside of the hospice's service area.</p> <p>(a) Standard: Physician services. The hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.</p> <p>(1) All physician employees and those under contract, must function under the supervision of the hospice medical director.</p> <p>(2) All physician employees and those under contract shall meet this requirement by either providing the services directly or through coordinating patient care with the attending physician.</p> <p>(3) If the attending physician is unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient.</p> <p>(b) Standard: Nursing services.</p> <p>(1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.</p> <p>(2) If State law permits registered nurses to see, treat, and write orders for patients, then registered nurses may provide services to beneficiaries receiving hospice care.</p> <p>(3) Highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive, may be provided under</p>	<p>admittance is eligible as required by Iowa Code section 135J.1(3) for hospice care;</p> <p>3. Be responsible for the medical component of the plan of care;</p> <p>4. Participate in developing and revising the plan of care;</p> <p>5. Arrange for continuity of the medical management in the attending physician's absence; and</p> <p>6. Monitor the condition of the patient and family by direct contact, or communication with the interdisciplinary team (IDT) and others.</p> <p>This rule is intended to implement Iowa Code section 135J.3(4).</p> <p>481—53.9(135J) Nursing services. Nursing services shall be planned and provided or supervised by a registered nurse who has a current Iowa license to practice nursing. The service shall be available 24 hours a day, seven days a week.</p> <p>53.9(1) A registered nurse shall assess patient and family nursing needs and develop a nursing plan of care to meet these needs.</p> <p>53.9(2) The nursing service staff shall:</p> <p><i>a.</i> Participate in IDT meetings to develop and amend the plan of care;</p> <p><i>b.</i> Provide nursing service in accordance with the overall plan of care developed by the IDT;</p> <p><i>c.</i> Consult with the patient and family regarding how to meet nursing and nursing-related needs of the patient;</p> <p><i>d.</i> Document nursing care given and observations made regarding patient, family reactions and status;</p> <p><i>e.</i> Consult with other care providers and the family to enhance continuity of care;</p> <p><i>f.</i> Develop and implement nursing service objectives, policies and procedures;</p> <p><i>g.</i> Develop job descriptions for all nursing personnel;</p> <p><i>h.</i> Establish staff schedules to meet patient and family needs and ensure 24-hour service;</p> <p><i>i.</i> Develop and implement orientation and training programs;</p> <p><i>j.</i> Develop and implement performance evaluation for the nursing staff;</p> <p><i>k.</i> Assign duties to nurses consistent with their education and experience; and</p>
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contract.

(c) Standard: Medical social services.

Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services.

(d) Standard: Counseling services.

Counseling services must be available to the patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process. Counseling services must include, but are not limited to, the following:

(1) **Bereavement counseling.** The hospice must:

- (i) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling.
- (ii) Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care.
- (iii) Ensure that bereavement services reflect the needs of the bereaved.
- (iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in § 418.204(c).

(2) **Dietary counseling.** Dietary counseling, when identified in the plan of care, must be performed by a qualified individual, which include dietitians as well as nurses and other individuals who are able to address and assure that the dietary needs of the patient are met.

(3) **Spiritual counseling.** The hospice must:

- (i) Provide an assessment of the patient's and family's spiritual needs.
- (ii) Provide spiritual counseling to meet

/. Facilitate periodic meetings of the professional nursing staff to evaluate the nursing care provided by hospice personnel.

53.9(3) Persons who are employed by, volunteer with or work under contract to a licensed hospice organization may administer medications only if they are also a licensed nurse, a licensed physician or a certified medication aide.

This rule is intended to implement Iowa Code section 135J.3(2).

***481 I.A.C. 53.12 (135J) Social services.** Social services shall be planned and provided or supervised by a person who has at least a bachelor's degree in social work from a school approved by the council on social work education. The social worker shall at least:

- 1. Consider the emotions and social support system of the patient and family;
- 2. Assess the ability of the family and the patient to function socially and to deal with their emotions;
- 3. Identify patient and family social service needs;
- 4. Participate on the IDT to develop and amend the plan of care;
- 5. Provide services in accordance with the plans of care developed by the IDT;
- 6. Document services provided and observations made regarding patient and family response and status; and
- 7. Cooperate and communicate with other providers and the family to enhance the continuity of care.

This rule is intended to implement Iowa Code section 135J.3(2).

***481—53.13(135J) Counseling services.** Counseling is the process of helping people adjust to the grief of illness, dying and loss. Counseling shall be provided in accordance with the plan of care. When the interdisciplinary team identifies the need for additional counseling services, a team member shall be designated to make an appropriate referral. No referrals may be made without the agreement of the patient and the family.

This rule is intended to implement Iowa

these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires.

(iii) Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability.

(iv) Advise the patient and family of this service.

Code section 135J.3(2).

***481—53.15(135J) Spiritual counseling.** Spiritual counseling shall be available to all patients and their families.

53.15(1) Spiritual counseling shall:

- a. Be based on the beliefs and values of the patient and family; and
- b. Be provided in accordance with the interdisciplinary plan of care.

53.15(2) If spiritual counseling is provided through a working relationship with clergy or other spiritual counselors in the community, there shall be ongoing communication between that counselor and the interdisciplinary care team.

53.15(3) There shall be written and implemented policies and procedures regarding spiritual counseling.

This rule is intended to implement Iowa Code section 135J.3(2).

***481 I.A.C. 53.19 (135J)**

Bereavement services. Bereavement services shall be available to each family after the death of a patient and shall be provided in accordance with family needs.

53.19(1) Bereavement services shall include:

- a. Exchange of information between people who provide bereavement services and team members who provided care before death;
- b. Consideration of the family's situation, including risk factors, used to develop a plan for services;
- c. Identification of types of help or intervention to be available and provided;
- d. Contact with the family after the death as required by their needs as documented in the plan of care; and
- e. A process to assess family reactions and hospice referrals for intervention deemed appropriate by the IDT.

53.19(2) There shall be written and implemented policies and procedures governing the delivery of bereavement services.

This rule is intended to implement Iowa Code section 135J.3(6).

<p>§ 418.66 Condition of participation: Nursing services—Waiver of requirement that substantially all nursing services be routinely provided directly by a hospice.</p> <p>(a) CMS may waive the requirement in § 418.64(b) that a hospice provide nursing services directly, if the hospice is located in a non-urbanized area. The location of a hospice that operates in several areas is considered to be the location of its central office. The hospice must provide evidence to CMS that it has made a good faith effort to hire a sufficient number of nurses to provide services. CMS may waive the requirement that nursing services be furnished by employees based on the following criteria:</p> <p>(1) The location of the hospice's central office is in a non-urbanized area as determined by the Bureau of the Census.</p> <p>(2) There is evidence that a hospice was operational on or before January 1, 1983 including the following:</p> <p>(i) Proof that the organization was established to provide hospice services on or before January 1, 1983.</p> <p>(ii) Evidence that hospice-type services were furnished to patients on or before January 1, 1983.</p> <p>(iii) Evidence that hospice care was a discrete activity rather than an aspect of another type of provider's patient care program on or before January 1, 1983.</p> <p>(3) By virtue of the following evidence that a hospice made a good faith effort to hire nurses:</p> <p>(i) Copies of advertisements in local newspapers that demonstrate recruitment efforts.</p> <p>(ii) Job descriptions for nurse employees.</p> <p>(iii) Evidence that salary and benefits are competitive for the area.</p> <p>(iv) Evidence of any other recruiting activities (for example, recruiting efforts at health fairs and contacts with nurses at other providers in the area).</p> <p>(b) Any waiver request is deemed to be granted unless it is denied within 60 days</p>	

<p>after it is received.</p> <p>(c) Waivers will remain effective for 1 year at a time from the date of the request.</p> <p>(d) If a hospice wishes to receive a 1-year extension, it must submit a request to CMS before the expiration of the waiver period, and certify that the conditions under which it originally requested the initial waiver have not changed since the initial waiver was granted.</p>	
<p>Non-Core Services</p> <p>§ 418.70 Condition of participation: Furnishing of non-core services.</p> <p>A hospice must ensure that the services described in § 418.72 through § 418.78 are provided directly by the hospice or under arrangements made by the hospice as specified in § 418.100. These services must be provided in a manner consistent with current standards of practice.</p>	
<p>§ 418.72 Condition of participation: Physical therapy, occupational therapy, and speech-language pathology.</p> <p>Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.</p>	
<p>§ 418.74 Waiver of requirement—Physical therapy, occupational therapy, speech language pathology, and dietary counseling.</p> <p>(a) A hospice located in a non-urbanized area may submit a written request for a waiver of the requirement for providing physical therapy, occupational therapy, speech-language pathology, and dietary counseling services. The hospice may seek a waiver of the requirement that it make physical therapy, occupational therapy, speech-language pathology, and dietary counseling services (as needed) available on a 24-hour basis. The hospice may also seek a waiver of the requirement that it provide dietary counseling directly. The hospice must provide evidence that it has made a good faith effort to meet the requirements for</p>	

<p>these services before it seeks a waiver. CMS may approve a waiver application on the basis of the following criteria:</p> <p>(1) The hospice is located in a non-urbanized area as determined by the Bureau of the Census.</p> <p>(2) The hospice provides evidence that it had made a good faith effort to make available physical therapy, occupational therapy, speech-language pathology, and dietary counseling services on a 24-hour basis and/or to hire a dietary counselor to furnish services directly. This evidence must include the following:</p> <p>(i) Copies of advertisements in local newspapers that demonstrate recruitment efforts.</p> <p>(ii) Physical therapy, occupational therapy, speech-language pathology, and dietary counselor job descriptions.</p> <p>(iii) Evidence that salary and benefits are competitive for the area.</p> <p>(iv) Evidence of any other recruiting activities (for example, recruiting efforts at health fairs and contact discussions with physical therapy, occupational therapy, speech-language pathology, and dietary counseling service providers in the area).</p> <p>(b) Any waiver request is deemed to be granted unless it is denied within 60 days after it is received.</p> <p>(c) An initial waiver will remain effective for 1 year at a time from the date of the request.</p> <p>(d) If a hospice wishes to receive a 1-year extension, it must submit a request to CMS before the expiration of the waiver period and certify that conditions under which it originally requested the waiver have not changed since the initial waiver was granted.</p>	
<p>§ 418.76 Condition of participation: Hospice aide and homemaker services.</p> <p>All hospice aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Homemaker services must be provided by individuals who meet the</p>	<p>441—81.16 Nurse aide requirements and training and testing programs. 81.16(1) (FOR NURSING FACILITIES)</p> <p><i>Deemed meeting of requirements.</i></p> <p>A nurse aide is deemed to satisfy the requirement of completing a training and competency evaluation approved by the department of inspections and appeals if</p>

personnel requirements specified in paragraph (j) of this section.

(a) Standard: Hospice aide qualifications.

(1) A qualified hospice aide is a person who has successfully completed one of the following:

(i) A training program and competency evaluation as specified in paragraphs (b) and (c) of this section respectively.

(ii) A competency evaluation program that meets the requirements of paragraph (c) of this section.

(iii) A nurse aide training and competency evaluation program approved by the State as meeting the requirements of § 483.151 through § 483.154 of this chapter, and is currently listed in good standing on the State nurse aide registry.

(iv) A State licensure program that meets the requirements of paragraphs (b) and (c) of this section.

(2) A hospice aide is not considered to have completed a program, as specified in paragraph (a)(1) of this section, if, since the individual's most recent completion of the program(s), there has been a continuous period of 24 consecutive months during which none of the services furnished by the individual as described in § 409.40 of this chapter were for compensation. If there has been a 24-month lapse in furnishing services, the individual must complete another program, as specified in paragraph (a)(1) of this section, before providing services.

(b) Standard: Content and duration of hospice aide classroom and supervised practical training.

(1) Hospice aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse, or a licensed practical nurse, who is under the supervision of a registered nurse. Classroom and supervised practical training combined must total at least 75 hours.

the nurse aide successfully completed a training and competency evaluation program before July 1, 1989. The aide would have satisfied this requirement if:

- a. At least 60 hours were substituted for 75 hours; and
- b. The aide has made up at least the difference in the number of hours in the program the aide completed and 75 hours in supervised practical nurse aide training or in regular in-service nurse education; or
- c. The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 hours' duration; or
- d. The person can demonstrate that the person served as a nurse aide at one or more facilities of the same employer in Iowa for at least 24 consecutive months before December 19, 1989; or
- e. The person completed, before July 1, 1989, a nurse aide training and competency evaluation program that the department of inspections and appeals determines would have met the requirements for approval at the time it was offered.

81.16(2) State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.

a. The department of inspections and appeals shall, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of [81.13\(19\)](#) "e" and [81.16\(1\)](#) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections and appeals approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of [81.16\(3\)](#).
2. A nurse aide competency evaluation program meets the requirements of

<p>(2) A minimum of 16 hours of classroom training must precede a minimum of 16 hours of supervised practical training as part of the 75 hours.</p> <p>(3) A hospice aide training program must address each of the following subject areas:</p> <p>(i) Communication skills, including the ability to read, write, and verbally report clinical information to patients, care givers, and other hospice staff.</p> <p>(ii) Observation, reporting, and documentation of patient status and the care or service furnished.</p> <p>(iii) Reading and recording temperature, pulse, and respiration.</p> <p>(iv) Basic infection control procedures.</p> <p>(v) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.</p> <p>(vi) Maintenance of a clean, safe, and healthy environment.</p> <p>(vii) Recognizing emergencies and the knowledge of emergency procedures and their application.</p> <p>(viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for the patient, his or her privacy, and his or her property.</p> <p>(ix) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist:</p> <p>(A) Bed bath.</p> <p>(B) Sponge, tub, and shower bath.</p> <p>(C) Hair shampoo (sink, tub, and bed).</p> <p>(D) Nail and skin care.</p> <p>(E) Oral hygiene.</p> <p>(F) Toileting and elimination.</p> <p>(x) Safe transfer techniques and ambulation.</p> <p>(xi) Normal range of motion and positioning.</p> <p>(xii) Adequate nutrition and fluid intake.</p> <p>(xiii) Any other task that the hospice may choose to have an aide perform. The hospice is responsible for training hospice aides, as needed, for skills not covered in the basic checklist, as described in paragraph (b)(3)(ix) of this section.</p>	<p>81.16(4).</p> <p>(2) Except as provided by paragraph 81.16(2) "f," the department of inspections and appeals shall not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility which, in the previous two years:</p> <ol style="list-style-type: none"> 1. Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or 2. Has been subject to an extended or partial extended survey; or 3. Has been assessed a civil money penalty of not less than \$5,000; or 4. Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or 5. Pursuant to state action, was closed or had its residents transferred; or 6. Has been terminated from participation in the Medicaid or Medicare program; or 7. Has been denied payment under subrule 81.40(1) or 81.40(2). <p>(3) Rescinded IAB 10/7/98, effective 12/1/98.</p> <p>c. Application process. Applications shall be submitted to the department of inspections and appeals before a new program begins and every two years thereafter on Form 427-0517, Application for Nurse aide Training. The department of inspections and appeals shall, within 90 days of the date of a request or receipt of additional information from the requester:</p> <ol style="list-style-type: none"> (1) Advise the requester whether or not the program has been approved; or (2) Request additional information from the requesting entity. <p>d. Duration of approval. The department of inspections and appeals shall not grant approval of a nurse aide training and competency evaluation program for a</p>
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<p>(4) The hospice must maintain documentation that demonstrates that the requirements of this standard are met.</p> <p>(c) Standard: Competency evaluation. An individual may furnish hospice aide services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in this section.</p> <p>(1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (b)(3)(iii), (b)(3)(ix), (b)(3)(x) and (b)(3)(xi) of this section must be evaluated by observing an aide's performance of the task with a patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient.</p> <p>(2) A hospice aide competency evaluation program may be offered by any organization, except as described in paragraph (f) of this section.</p> <p>(3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate.</p> <p>(4) A hospice aide is not considered competent in any task for which he or she is evaluated as unsatisfactory. An aide must not perform that task without direct supervision by a registered nurse until after he or she has received training in the task for which he or she was evaluated as "unsatisfactory," and successfully completes a subsequent evaluation. A hospice aide is not considered to have successfully completed a competency evaluation if the aide has an "unsatisfactory" rating in more than one of the required areas.</p> <p>(5) The hospice must maintain documentation that demonstrates the requirements of this standard are being met.</p> <p>(d) Standard: In-service training. A hospice aide must receive at least 12 hours of in-service training during each 12-month period. In-service training may</p>	<p>period longer than two years. A program shall notify the department of inspections and appeals and the department of inspections and appeals shall review that program when there are substantive changes made to that program within the two-year period.</p> <p>e. Withdrawal of approval.</p> <p>(1) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program offered by or in a facility described in 81.16(2) "b"(2).</p> <p>(2) The department of inspections and appeals may withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program if the department of inspections and appeals determines that any of the applicable requirements for approval or registry, as set out in subrule 81.16(3) or 81.16(4), are not met.</p> <p>(3) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or a nurse aide competency evaluation program if the entity providing the program refuses to permit unannounced visits by the department of inspections and appeals.</p> <p>(4) If the department of inspections and appeals withdraws approval of a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall notify the program in writing, indicating the reasons for withdrawal of approval of the program. Students who have started a training and competency evaluation program from which approval has been withdrawn shall be allowed to complete the course.</p> <p>f. An exception to subparagraph 81.16(2) "b"(2) may be granted by the department of inspections and appeals (DIA) for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:</p> <p>(1) The facility has submitted Form 470-3494, Nurse aide Education Program</p>
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<p>occur while an aide is furnishing care to a patient.</p> <p>(1) In-service training may be offered by any organization, and must be supervised by a registered nurse.</p> <p>(2) The hospice must maintain documentation that demonstrates the requirements of this standard are met.</p> <p>(e) Standard: Qualifications for instructors conducting classroom and supervised practical training. Classroom and supervised practical training must be performed by a registered nurse who possesses a minimum of 2 years nursing experience, at least 1 year of which must be in home care, or by other individuals under the general supervision of a registered nurse.</p> <p>(f) Standard: Eligible competency evaluation organizations. A hospice aide competency evaluation program as specified in paragraph (c) of this section may be offered by any organization except by a home health agency that, within the previous 2 years:</p> <p>(1) Had been of compliance with the requirements of § 484.36(a) and (b) of this chapter.</p> <p>(2) Permitted an individual that does not meet the definition of a “qualified home health aide” as specified in § 484.36(a) of this chapter to furnish home health aide services (with the exception of licensed health professionals and volunteers).</p> <p>(3) Had been subjected to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State).</p> <p>(4) Had been assessed a civil monetary penalty of \$5,000 or more as an intermediate sanction.</p> <p>(5) Had been found by CMS to have compliance deficiencies that endangered the health and safety of the home health agency’s patients and had temporary management appointed to oversee the management of the home health agency.</p> <p>(6) Had all or part of its Medicare payments suspended.</p> <p>(7) Had been found by CMS or the State under any Federal or State law to have:</p>	<p>Waiver Request, to the DIA to request a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility.</p> <p>(2) The 75-hour nurse aide training is offered in a facility by an approved nurse aide training and competency evaluation program (NATCEP).</p> <p>(3) No other NATCEP program is offered within 30 minutes’ travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.</p> <p>(4) The facility is in substantial compliance with the federal requirements related to nursing care and services.</p> <p>(5) The facility is not a poor performing facility.</p> <p>(6) Employees of the facility do not function as instructors for the program unless specifically approved by DIA.</p> <p>(7) The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for ensuring that program requirements are met.</p> <p>(8) The NATCEP has submitted an evaluation to the DIA indicating that an adequate teaching and learning environment exists for conducting the course.</p> <p>(9) The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the DIA to register any concerns encountered during the course.</p> <p>(10) The NATCEP shall require the program instructor and students to complete an evaluation of the course. The instructor shall return the completed evaluations to the NATCEP which shall return the evaluations to DIA.</p> <p>81.16(3) Requirements for approval of a nurse aide training and competency evaluation program. The department has designated the department of inspections and appeals to approve required nurse aide training and testing programs. Policies and procedures governing approval of the programs are set forth in</p>
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<p>(i) Had its participation in the Medicare program terminated.</p> <p>(ii) Been assessed a penalty of \$5,000 or more for deficiencies in Federal or State standards for home health agencies.</p> <p>(iii) Been subjected to a suspension of Medicare payments to which it otherwise would have been entitled.</p> <p>(iv) Operated under temporary management that was appointed by a governmental authority to oversee the operation of the home health agency and to ensure the health and safety of the home health agency's patients.</p> <p>(v) Been closed by CMS or the State, or had its patients transferred by the State.</p> <p>(g) Standard: Hospice aide assignments and duties.</p> <p>(1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. 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.</p> <p>(2) A hospice aide provides services that are:</p> <p>(i) Ordered by the interdisciplinary group.</p> <p>(ii) Included in the plan of care.</p> <p>(iii) Permitted to be performed under State law by such hospice aide.</p> <p>(iv) Consistent with the hospice aide training.</p> <p>(3) The duties of a hospice aide include the following:</p> <p>(i) The provision of hands-on personal care.</p> <p>(ii) The performance of simple procedures as an extension of therapy or nursing services.</p> <p>(iii) Assistance in ambulation or exercises.</p> <p>(iv) Assistance in administering medications that are ordinarily self administered.</p> <p>(4) Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a</p>	<p>these rules.</p> <p>a. For a nurse aide training and competency evaluation program to be approved by the department of inspections and appeals, it shall, at a minimum:</p> <p>(1) Consist of no less than 75 clock hours of training.</p> <p>(2) Include at least the subjects specified in 81.16(3).</p> <p>(3) Include at least 15 hours of laboratory experience, 30 hours of classroom instruction (the first 16 hours of which must occur before the nurse aide has resident contact) and 30 hours of supervised clinical training. Supervised clinical training means training in a setting in which the trainee demonstrates knowledge while performing tasks on a resident under the general supervision of a registered nurse or licensed practical nurse.</p> <p>(4) Ensure that students do not independently perform any services for which they have not been trained and found proficient by the instructor. It shall also ensure that students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse.</p> <p>(5) Meet the following requirements for instructors who train nurse aides:</p> <ol style="list-style-type: none"> 1. The training of nurse aides shall be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which shall be in the provision of long-term care facility services. 2. Instructors shall be registered nurses and shall have completed a course in teaching adults or have experience teaching adults or supervising nurse aides. 3. In a facility-based program, when the director of nursing is a registered nurse, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility. The director of nursing is
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<p>registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities. Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures.</p> <p>(h) Standard: Supervision of hospice aides.</p> <p>(1) A registered nurse must make an on-site visit to the patient's home:</p> <p>(i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.</p> <p>(ii) If an area of concern is noted by the supervising nurse, then the hospice must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care.</p> <p>(iii) If an area of concern is verified by the hospice during the on-site visit, then the hospice must conduct, and the hospice aide must complete a competency evaluation in accordance with § 418.76(c).</p> <p>(2) A registered nurse must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.</p> <p>(3) The supervising nurse must assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include, but is not limited to—</p> <p>(i) Following the patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse.</p> <p>(ii) Creating successful interpersonal relationships with the patient and family.</p> <p>(iii) Demonstrating competency with assigned tasks.</p> <p>(iv) Complying with infection control policies and procedures.</p> <p>(v) Reporting changes in the patient's condition.</p> <p>(i) Standard: Individuals furnishing</p>	<p>prohibited from performing the actual training.</p> <p>4. Other personnel from the health professions may supplement the instructor. Supplemental personnel shall have at least one year of experience in their fields.</p> <p>5. The ratio of qualified trainers to students shall not exceed one instructor for every ten students in the clinical setting.</p> <p>(6) Contain information regarding competency evaluation through written or oral and skills testing.</p> <p>b. The curriculum of the nurse aide training program shall include:</p> <p>(1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:</p> <ol style="list-style-type: none"> 1. Communication and interpersonal skills. 2. Infection control. 3. Safety and emergency procedures including the Heimlich maneuver. 4. Promoting residents' independence. 5. Respecting residents' rights. <p>(2) Basic nursing skills:</p> <ol style="list-style-type: none"> 1. Taking and recording vital signs. 2. Measuring and recording height and weight. 3. Caring for the residents' environment. 4. Recognizing abnormal changes in body functioning and the importance of reporting these changes to a supervisor. 5. Caring for residents when death is imminent. <p>(3) Personal care skills, including, but not limited to:</p> <ol style="list-style-type: none"> 1. Bathing. 2. Grooming, including mouth care. 3. Dressing. 4. Toileting. 5. Assisting with eating and
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<p>Medicaid personal care aide-only services under a Medicaid personal care benefit. An individual may furnish personal care services, as defined in § 440.167 of this chapter, on behalf of a hospice agency.</p> <p>(1) Before the individual may furnish personal care services, the individual must be found competent by the State (if regulated by the State) to furnish those services. The individual only needs to demonstrate competency in the services the individual is required to furnish.</p> <p>(2) Services under the Medicaid personal care benefit may be used to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care.</p> <p>(3) The hospice must coordinate its hospice aide and homemaker services with the Medicaid personal care benefit to ensure the patient receives the hospice aide and homemaker services he or she needs.</p> <p>(j) Standard: Homemaker qualifications. A qualified homemaker is—</p> <p>(1) An individual who meets the standards in § 418.202(g) and has successfully completed hospice orientation addressing the needs and concerns of patients and families coping with a terminal illness; or</p> <p>(2) A hospice aide as described in § 418.76.</p> <p>(k) Standard: Homemaker supervision and duties.</p> <p>(1) Homemaker services must be coordinated and supervised by a member of the interdisciplinary group.</p> <p>(2) Instructions for homemaker duties must be prepared by a member of the interdisciplinary group.</p> <p>(3) Homemakers must report all concerns about the patient or family to the member of the interdisciplinary group who is coordinating homemaker services.</p>	<p>hydration.</p> <ol style="list-style-type: none"> 6. Proper feeding techniques. 7. Skin care. 8. Transfers, positioning, and turning. <p>(4) Mental health and social service needs:</p> <ol style="list-style-type: none"> 1. Modifying aide's behavior in response to residents' behavior. 2. Awareness of developmental tasks associated with the aging process. 3. How to respond to resident behavior. 4. Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity. 5. Using the resident's family as a source of emotional support. <p>(5) Care of cognitively impaired residents:</p> <ol style="list-style-type: none"> 1. Techniques for addressing the unique needs and behaviors of persons with dementia (Alzheimer's and others). 2. Communicating with cognitively impaired residents. 3. Understanding the behavior of cognitively impaired residents. 4. Appropriate responses to the behavior of cognitively impaired residents. 5. Methods of reducing the effects of cognitive impairments. <p>(6) Basic restorative services:</p> <ol style="list-style-type: none"> 1. Training the resident in self-care according to the resident's ability. 2. Use of assistive devices in transferring, ambulation, eating and dressing. 3. Maintenance of range of motion. 4. Proper turning and positioning in bed and chair. 5. Bowel and bladder training. 6. Care and use of prosthetic and
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orthotic devices.

(7) Residents' rights:

1. Providing privacy and maintenance of confidentiality.
2. Promoting the residents' rights to make personal choices to accommodate their needs.
3. Giving assistance in resolving grievances and disputes.
4. Providing needed assistance in getting to and participating in resident and family groups and other activities.
5. Maintaining care and security of residents' personal possessions.
6. Promoting the residents' rights to be free from abuse, mistreatment, and neglect and the need to report any instances of this type of treatment to appropriate facility staff.
7. Avoiding the need for restraints in accordance with current professional standards.

c. Prohibition of charges.

(1) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program or competency evaluation program may be charged for any portion of the program including any fees for textbooks or other required evaluation or course materials.

(2) If a person who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program, the facility shall reimburse the nurse aide for costs incurred in completing the program or competency evaluation on a pro rata basis during the period in which the person is employed as a nurse aide. The formula for paying the nurse aides on a

	<p>pro rata basis shall be as follows:</p> <ol style="list-style-type: none">1. Add all costs incurred by the aides for the course, books, and tests.2. Divide the total arrived at in No.1 above by 12 to prorate the costs over a one-year period and establish a monthly rate.3. The aide shall be reimbursed the monthly rate each month the aide works at the facility until one year from the time the aide completed the course. <p><i>d.</i> Setting and equipment. The classroom shall have appropriate equipment, be of adequate size, and not interfere with resident activities.</p> <p><i>e.</i> Records and reports. Nurse aide education programs approved by the department of inspections and appeals shall:</p> <ol style="list-style-type: none">(1) Notify the department of inspections and appeals:<ol style="list-style-type: none">1. Of dates of classroom and clinical sessions as well as location of classrooms and clinical practice sites before each course begins and if the course is canceled.2. When a facility or other training entity will no longer be offering nurse aide training courses.3. Whenever the person coordinating the training program is hired or terminates employment.(2) Keep a list of faculty members and their qualifications available for department review.(3) Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.(4) Complete a lesson plan for each unit which includes behavioral objectives, a topic outline and student activities and experiences.(5) Provide the student, within 30 days of the last class period, evidence of
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	<p>having successfully completed the course.</p> <p>81.16(4) Nurse aide competency evaluation.</p> <p>A competency evaluation program shall contain a written or oral portion and a skills demonstration portion.</p> <p><i>a.</i> Notification to person. The department of inspections and appeals shall advise in advance any person who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the state's nurse aide registry.</p> <p><i>b.</i> Content of the competency evaluation program.</p> <p>(1) Written or oral examinations. The competency evaluation shall:</p> <ol style="list-style-type: none">1. Allow an aide to choose between a written and oral examination.2. Address each of the course requirements listed in 81.16(3) "b."3. Be developed from a pool of test questions, only a portion of which is used in any one examination.4. Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations.5. If oral, be read from a prepared text in a neutral manner.6. Be tested for reliability and validity using a nationally recognized standard as determined by the department of education.7. Be in English, unless the prevailing language used in the facility where a nurse aide will be working is other than English. <p>(2) Demonstration of skills. The skills demonstration evaluation shall consist of a demonstration of randomly selected items drawn from a pool consisting of tasks generally performed by nurse aides. This pool of skills shall include all of the personal care skills listed in 81.16(3) "b"(3).</p> <p><i>c.</i> Administration of the competency</p>
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	<p>evaluation.</p> <p>(1) The competency examination shall be administered and evaluated only by an entity approved by the department of inspections and appeals, which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.</p> <p>(2) Charging nurse aides for competency testing is prohibited in accordance with 81.16(3) "c. "</p> <p>(3) The skills demonstration part of the evaluation shall be performed in a facility or laboratory setting comparable to the setting in which the person will function as a nurse aide and shall be administered and evaluated by a registered nurse with at least one year's experience in providing care for the elderly or the chronically ill of any age.</p> <p><i>d.</i> Facility proctoring of the competency evaluation.</p> <p>(1) The competency evaluation may, at the nurse aide's option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is prohibited from being a competency evaluation site.</p> <p>(2) The department of inspections and appeals may permit the competency evaluation to be proctored by facility personnel if the department of inspections and appeals finds that the procedure adopted by the facility ensures that the competency evaluation program:</p> <ol style="list-style-type: none">1. Is secure from tampering.2. Is standardized and scored by a testing, educational, or other organization approved by the department of inspections and appeals.3. Requires no scoring by facility personnel. <p>(3) The department of inspections and appeals shall retract the right to proctor nurse aide competency evaluations from facilities in which the department of inspections and appeals finds any evidence of impropriety, including evidence of tampering by facility staff.</p>
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	<p><i>e.</i> Successful completion of the competency evaluation program.</p> <p>(1) A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test.</p> <p>(2) A record of successful completion of the competency evaluation shall be included in the nurse aide registry within 30 days of the date the person is found to be competent.</p> <p>(3) The competency testing entity shall inform the nurse aide of the test score within 30 calendar days of the completion of the test and shall inform the nurse aide registry of the nurse aide's scores within 20 calendar days after the test is administered.</p> <p><i>f.</i> Unsuccessful completion of the competency evaluation program.</p> <p>(1) If the person does not complete the evaluation satisfactorily, the person shall be advised in writing within ten working days after the test is scored:</p> <ol style="list-style-type: none">1. Of the areas which the person did not pass.2. That the person has three opportunities to take the evaluation. <p>(2) Each person shall have three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course shall be taken or retaken before the test can be taken again.</p> <p><i>g.</i> Storage of evaluation instrument. The person responsible for administering a competency evaluation shall provide secure storage of the evaluation instruments when they are not being administered or processed.</p> <p><i>h.</i> Application process. Entities wishing to secure approval for a competency evaluation program shall submit a copy of the evaluation plan and procedures to the department of inspections and appeals. The department of inspections and appeals shall notify the applicant of its decision within 90 days of receipt of</p>
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the application. The notification shall include the reason for not giving approval if approval is denied and the applicable rule citation.

81.16(5)

Registry of nurse aides.

a. Establishment of registry. The department of inspections and appeals shall establish and maintain a registry of nurse aides that meets the following requirements. The registry:

- (1) Shall include, at a minimum, the information required in [81.16\(5\) "c."](#)
- (2) Shall be sufficiently accessible to meet the needs of the public and health care providers promptly.
- (3) Shall provide that any response to an inquiry that includes a finding of abuse, neglect, mistreatment of a resident or misappropriation of property also include any statement made by the nurse aide which disputes the finding.

b. Registry operation.

- (1) Only the department of inspections and appeals may place on the registry findings of abuse, neglect, mistreatment of a resident or misappropriation of property.
- (2) The department of inspections and appeals shall determine which persons:

1. Have successfully completed a nurse aide training and competency evaluation program or nurse aide competency evaluation program.
2. Have been deemed as meeting these requirements.
3. Do not qualify to remain on the registry because they have performed no nursing or nursing-related services for monetary compensation during a period of 24 consecutive months.

(3) The department of inspections and appeals shall not impose any charges related to registration on persons listed in the registry.

(4) The department of inspections and appeals shall provide information on the registry promptly.

	<p>c. Registry content.</p> <p>(1) The registry shall contain at least the following information on each person who has successfully completed a nurse aide training and competency evaluation program or competency evaluation program which was approved by the department of inspections and appeals or who may function as a nurse aide because of having been deemed competent:</p> <ol style="list-style-type: none">1. The person's full name.2. Information necessary to identify each person.3. The date the person became eligible for placement in the registry through successfully completing a nurse aide training and competency evaluation program or competency evaluation or by being deemed competent.4. The following information on any finding by the department of inspections and appeals of abuse, neglect, mistreatment of residents or misappropriation of property by the person: documentation of the department of inspections and appeals' investigation, including the nature of the allegation and the evidence that led the department of inspections and appeals to conclude that the allegation was valid; the date of the hearing, if the person chose to have one, and its outcome; and a statement by the person disputing the allegation, if the person chooses to make one. This information must be included in the registry within ten working days of the finding and shall remain in the registry permanently, unless the finding was made in error, the person was found not guilty in a court of law, or the department of inspections and appeals is notified of the person's death.5. A record of known convictions by a court of law of a person
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	<p>convicted of abuse, neglect, mistreatment or misappropriation of resident property.</p> <p>(2) The registry shall remove entries for persons who have performed no nursing or nursing-related services for monetary compensation for a period of 24 consecutive months unless the person's registry entry includes documented findings or convictions by a court of law of abuse, neglect, mistreatment or misappropriation of property.</p> <p>d. Disclosure of information. The department of inspections and appeals shall:</p> <p>(1) Disclose all of the information listed in 81.16(5) "c"(1), (3), and (4) to all requesters and may disclose additional information it deems necessary.</p> <p>(2) Promptly provide persons with all information contained in the registry about them when adverse findings are placed on the registry and upon request. Persons on the registry shall have sufficient opportunity to correct any misstatements or inaccuracies contained in the registry.</p> <p>e. Placement of names on nurse aide registry. The facility shall ensure that the name of each person employed as a nurse aide in a Medicare- or Medicaid-certified nursing facility in Iowa is submitted to the registry. The telephone number of the registry is (515)281-4963. The address is Nurse aide Registry, Lucas State Office Building, Des Moines, Iowa 50319-0083.</p> <p>(1) Persons employed as nurse aides shall complete Form 427-0496, Nurse aide Registry Application, within the first 30 days of employment. This form shall be submitted to the department of inspections and appeals. Form 427-0496 may be obtained by calling or writing the nurse aide registry.</p> <p>(2) A nurse aide who is not employed may apply for inclusion on the registry by submitting a copy of completed Form 427-0496 to the nurse aide registry.</p> <p>(3) When the registry has received a signed application and entered the required training and testing information</p>
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on the registry, a letter will be sent to the nurse aide that includes all the information the registry has on the nurse aide. A nurse aide may obtain a copy of the information on the registry by writing the nurse aide registry and requesting the information. The letter requesting the information must include the nurse aide's social security number, current or last facility of employment, date of birth and current mailing address and must be signed by the nurse aide.

81.16(6) Hearing.

When there is an allegation of abuse against a nurse aide, the department of inspections and appeals shall investigate that allegation. When the investigation by the department of inspections and appeals makes a finding of an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing. The nurse aide shall have 30 days to request a hearing. The request shall be in writing and shall be sent to the department of inspections and appeals. The hearing shall be held pursuant to department of inspections and appeals rules [481—Chapter 10](#). After 30 days, if the nurse aide fails to appeal, or when all appeals are exhausted, the nurse aide registry will include a notation that the nurse aide has a founded abuse report on record if the final decision indicates the nurse aide performed an abusive act.

81.16(7) Appeals.

Adverse decisions made by the department of inspections and appeals in administering these rules may be appealed pursuant to department of inspections and appeals rules [481—Chapter 10](#).

This rule is intended to implement Iowa Code section 249A.4.

641I.A.C. 80.10

**Department of Public Health
Home care aide services.**

Home care aide services are intended to enhance the capacity of consumers to attain or maintain their independence. Trained and supervised direct care workers provide services to consumers

	<p>who, due to the absence, incapacity or limitations of the usual homemaker, are experiencing stress or crisis.</p> <p>80.10(1) Program purpose. The purpose of this program is to reduce, prevent or delay inappropriate institutionalization of consumers and to preserve families through the provision of supportive services by direct care workers who have completed training and are professionally supervised.</p> <p>80.10(2) Scope. The direct care worker provides services for consumers by following a plan of care identifying assigned tasks. A direct care worker participates in activities to safeguard the health and wellness of the community and to implement core public health functions and essential public health services.</p> <p>80.10(3) Authorized agency. <i>a.</i> The authorized agency shall establish policies for supervision of direct care workers. <i>b.</i> The authorized agency shall ensure that each direct care worker has completed adequate training and demonstrated competency for each task assigned. The required preservice education for direct care workers is outlined in the following chart: (See last page of document for chart)</p> <p>80.10(4) Professional staff as providers of home care aide services. An individual who is in the process of receiving or who has completed the training required for LPN or RN licensure or who possesses an associate's degree or higher in social work, sociology, home economics or other health or human services field may be assigned to provide home care aide services if the following conditions are met: <i>a.</i> Services or tasks assigned are appropriate to the individual's prior training. <i>b.</i> Orientation to home care is conducted. Orientation includes adaptation of the individual's knowledge and skills from prior education to the home setting and</p>
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	<p>to the role of the home care aide.</p> <p>80.10(5) Care coordinator and service manager qualifications.</p> <p><i>a.</i> An individual performing care coordination or service management shall meet one of the following criteria:</p> <ul style="list-style-type: none">(1) Be a registered nurse licensed to practice in the state of Iowa.(2) Possess a bachelor's degree in family and consumer science, education, social work or other health or human services field.(3) Be a licensed practical nurse with a current Iowa license. <p><i>b.</i> A home care aide with an equivalent of two years' experience may be delegated care coordination/service management duties as long as a qualified individual who meets one of the criteria in paragraph "a" retains responsibility and provides supervision and evidence of supervision.</p> <p><i>c.</i> An individual who has provided home care aide care coordination and service management prior to June 30, 2007, shall be considered qualified to continue in the position.</p> <p>80.10(6) A qualified care coordinator or service manager may provide direct care services as appropriate to the individual's level of education and competency for the assignment.</p> <p>80.10(7) The service manager's scheduling duty may be delegated to an individual not possessing one of the qualifications in paragraph 80.10(5) "a" provided that a qualified individual who meets one of the qualifications in 80.10(5) "a" retains responsibility and provides supervision and evidence of supervision.</p> <p>80.10(8) Consumer records. The authorized agency shall maintain records for each consumer. The records shall include:</p> <ul style="list-style-type: none"><i>a.</i> An initial assessment.<i>b.</i> A plan of care.<i>c.</i> Assignment of direct care worker.<i>d.</i> Assignment of tasks.<i>e.</i> Reassessment.<i>f.</i> Update of plan of care.<i>g.</i> Direct care worker narrative notes.
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	<p><i>h.</i> Documented supervision.</p> <p>80.10(9) Appropriation. The appropriation to each county is determined by the following formula: 15 percent of the total allocation shall be divided so that an equal amount is available for use in each county in the state. The following percentages of the remaining 85 percent shall be allocated to each county according to that county's proportion of state residents with the following demographic characteristics:</p> <p><i>a.</i> Sixty percent according to the number of elderly persons living in the county.</p> <p><i>b.</i> Twenty percent according to the number of persons below the federal poverty guidelines living in the county.</p> <p><i>c.</i> Twenty percent according to the number of substantiated cases of child abuse in the county during the three most recent years for which data is available.</p>
<p>§ 418.78 Conditions of participation— Volunteers.</p> <p>The hospice must use volunteers to the extent specified in paragraph (e) of this section. These volunteers must be used in defined roles and under the supervision of a designated hospice employee.</p> <p>(a) Standard: Training. The hospice must maintain, document, and provide volunteer orientation and training that is consistent with hospice industry standards.</p> <p>(b) Standard: Role. Volunteers must be used in day-to-day administrative and/or direct patient care roles.</p> <p>(c) Standard: Recruiting and retaining. The hospice must document and demonstrate viable and ongoing efforts to recruit and retain volunteers.</p> <p>(d) Standard: Cost saving. The hospice must document the cost savings achieved through the use of volunteers. Documentation must include the following:</p> <p>(1) The identification of each position that is occupied by a volunteer.</p> <p>(2) The work time spent by volunteers occupying those positions.</p>	<p>*481 I.A.C. 53.14 (135J) Volunteer services. Each hospice shall provide volunteer services to meet patient and family needs. A coordinator of volunteer services shall be designated to implement written policies and procedures.</p> <p>53.14(1) Each volunteer shall have at least 14 hours of education provided by the hospice before being assigned to a patient and family. The following topics shall be included in the educational program:</p> <p><i>a.</i> Hospice concept and philosophy;</p> <p><i>b.</i> Symptom control;</p> <p><i>c.</i> Infection control;</p> <p><i>d.</i> Home care skills;</p> <p><i>e.</i> Safety measures and transfer techniques;</p> <p><i>f.</i> Stress management;</p> <p><i>g.</i> Communication needs;</p> <p><i>h.</i> Psychosocial needs;</p> <p><i>i.</i> Spiritual needs;</p> <p><i>j.</i> Death, dying and grief; and</p> <p><i>k.</i> Funerals and alternative rituals.</p> <p>53.14(2) The hospice shall offer at least two hours of in-service training each quarter.</p> <p>This rule is intended to implement Iowa</p>

<p>(3) Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions identified in paragraph (d)(1) of this section for the amount of time specified in paragraph (d)(2) of this section.</p> <p>(e) Standard: Level of activity. Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked.</p>	<p>Code section 135J.3(2).</p>
<p>Subpart D--Conditions of Participation: Organizational Environment</p>	
<p>§ 418.100 Condition of Participation: Organization and administration of services.</p> <p>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 the terminal illness and related conditions.</p> <p>(a) Standard: Serving the hospice patient and family.</p> <p>The hospice must provide hospice care that—</p> <p>(1) Optimizes comfort and dignity; and</p> <p>(2) Is consistent with patient and family needs and goals, with patient needs and goals as priority.</p> <p>(b) Standard: Governing body and administrator. A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body.</p>	<p>*481 I.A.C. 53.4 (135J)Governing body.</p> <p>The hospice shall have a local governing body which consists of people who represent the geographic area for which the hospice intends to provide service.</p> <p>53.4(1) The governing body shall:</p> <p><i>a.</i> Develop a written mission statement, goals and objectives for the hospice and meet with sufficient regularity to ensure accomplishment of those goals and objectives;</p> <p><i>b.</i> Develop, amend and implement bylaws;</p> <p><i>c.</i> Assume responsibility for the total operation of the hospice;</p> <p><i>d.</i> Appoint an administrator whose qualifications and duties are defined in writing and who has authority to manage the business affairs and to direct all programs of the hospice;</p> <p><i>e.</i> Develop the budget and monitor the fiscal affairs of the hospice;</p> <p><i>f.</i> Provide for medical direction by a licensed physician;</p> <p><i>g.</i> Provide appropriate, qualified personnel in sufficient quantity to ensure availability of hospice services listed below, 24 hours a day, seven days a week;</p> <p><i>h.</i> Develop and implement written policies and procedures relating to:</p> <p>(1) Admission and discharge criteria,</p>

<p>(c) Standard: Services. (1) A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice: (i) Nursing services. (ii) Medical social services. (iii) Physician services. (iv) Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling. (v) Hospice aide, volunteer, and homemaker services. (vi) Physical therapy, occupational therapy, and speech-language pathology services. (vii) Short-term inpatient care. (viii) Medical supplies (including drugs and biologicals) and medical appliances. (2) Nursing services, physician services, and drugs and biologicals (as specified in § 418.106) must be made routinely available on a 24-hour basis 7 days a week. Other covered services must be available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family.</p> <p>(d) Standard: Continuation of care. A hospice may not discontinue or reduce care provided to a Medicare or Medicaid beneficiary because of the beneficiary's inability to pay for that care.</p> <p>(e) Standard: Professional management responsibility. A hospice that has a written agreement with another agency, individual, or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care. Arranged services must be supported by written agreements that require that all services be— (1) Authorized by the hospice; (2) Furnished in a safe and effective manner by qualified personnel; and (3) Delivered in accordance with the patient's plan of care.</p> <p>(f) Standard: Hospice multiple locations.</p>	<p>(2) Response to referrals, (3) Medical direction, (4) Physician services, (5) Nursing services, (6) Nutritional services, (7) Pharmacy services, (8) Social services, (9) Volunteer services, (10) Spiritual services, (11) Patient and family education, (12) Bereavement services, (13) Staff response to death at home and in institutions, (14) Coordination and communication between all agencies serving the patient and family, (15) Communication with community agencies, and (16) Community education efforts; <i>i.</i> Develop and implement written personnel policies; and <i>j.</i> Develop and implement a written plan for review of the services delivered.</p> <p>53.4(2) The governing body shall ensure that someone is responsible to: <i>a.</i> Organize and direct the ongoing functions of the hospice program; <i>b.</i> Meet the requirements of the written job descriptions; <i>c.</i> Maintain liaison with the governing body and staff to ensure administrative control and professional supervision over all patient and family services furnished; <i>d.</i> Provide orientation and in-service training for all staff which covers the physical, emotional, spiritual and social needs of hospice patients and their families during the final stages of illness, at death and during grief; <i>e.</i> Plan, organize, implement, guide and evaluate the program; <i>f.</i> Formulate and conduct a review of policies and procedures, including quality assurance; and <i>g.</i> Ensure that all required reports and records are completed, submitted and maintained. This includes personnel, administrative and clinical records. This rule is intended to implement Iowa Code section 135J.3.</p> <p>*481 I.A.C. 53.16(135J) Optional</p>
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If a hospice operates multiple locations, it must meet the following requirements:

(1) Medicare approval.

(i) All hospice multiple locations must be approved by Medicare before providing hospice care and services to Medicare patients.

(ii) The multiple location must be part of the hospice and must share administration, supervision, and services with the hospice issued the certification number.

(iii) The lines of authority and professional and administrative control must be clearly delineated in the hospice's organizational structure and in practice, and must be traced to the location that issued the certification number.

(iv) The determination that a multiple location does or does not meet the definition of a multiple location, as set forth in this part, is an initial determination, as set forth in § 498.3.

(2) The hospice must continually monitor and manage all services provided at all of its locations to ensure that services are delivered in a safe and effective manner and to ensure that each patient and family receives the necessary care and services outlined in the plan of care, in accordance with the requirements of this subpart and subparts A and C of this section.

(g) Standard: Training.

(1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact.

(2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties.

(3) A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the inservice

services. Optional services are services provided by the hospice which are not required. Examples are home health aide, therapy and respite. The following apply to the provision of all optional services provided by a hospice:

53.16(1) All service providers shall be oriented to the hospice concept and philosophy.

53.16(2) All services shall be provided in accordance with the interdisciplinary plan of care.

53.16(3) Written and implemented policies and procedures shall:

a. Identify service providers;

b. Identify the person who will supervise the provision of services;

c. Require documentation of services provided and patient and family response; and

d. Describe a mechanism for evaluating quality of care provided.

This rule is intended to implement Iowa Code section 135J.1(7).

***481—53.17(135J) Contracted**

services. A hospice may contract with other health care providers for the provision of all services.

53.17(1) Contracts shall be written and clearly delineate the authority and responsibility of each party to the contract.

53.17(2) The hospice shall maintain responsibility for coordinating and administering the hospice program.

53.17(3) Contracting for a service does not absolve the hospice of legal responsibility for provision of that service.

53.17(4) The hospice shall inform the patient whether the hospice is paying for the contracted services.

This rule is intended to implement Iowa Code section 135J.3(2).

<p>training provided during the previous 12 months</p>	
<p>§ 418.102 Condition of participation: Medical director. The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with the hospice. When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director.</p> <p>(a) Standard: Medical director contract. (1) A hospice may contract with either of the following— (i) A self-employed physician; or (ii) A physician employed by a professional entity or physicians group. When contracting for medical director services, the contract must specify the physician who assumes the medical director responsibilities and obligations.</p> <p>(b) Standard: Initial certification of terminal illness. The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that it is anticipated that the patient’s life expectancy is 6 months or less if the illness runs its normal course. The physician must consider the following when making this determination: (1) The primary terminal condition; (2) Related diagnosis(es), if any; (3) Current subjective and objective medical findings; (4) Current medication and treatment orders; and (5) Information about the medical management of any of the patient’s conditions unrelated to the terminal illness.</p> <p>(c) Standard: Recertification of the terminal illness. Before the recertification period for each patient, as described in § 418.21(a), the medical director or physician designee must review the patient’s clinical information.</p> <p>(d) Standard: Medical director responsibility. The medical director or physician designee has responsibility for</p>	<p>*481 I.A.C. 53.7 Medical director. Each hospice shall have a medical director who is a physician licensed to practice medicine pursuant to Iowa Code chapter 148, 150 or 150A. The medical director shall:</p> <ol style="list-style-type: none"> 1. Be a member of the interdisciplinary team; 2. Monitor the quality of care provided; 3. Assist in providing assurance of the quality of care provided to the patient and family; 4. Maintain liaison with the attending physician; 5. Review clinical material from the patient’s attending physician to certify the prognosis as anticipated by that physician; 6. Participate in providing direction for the medical component of care; 7. Participate in resolving conflicts regarding care to be provided; 8. Name a qualified physician to be available in the medical director’s absence; and 9. Participate in the development and review of patient and family care policies, procedures and protocols. <p>This rule is intended to implement Iowa Code section 135J.3(1).</p>

<p>the medical component of the hospice's patient care program.</p>	
<p>§ 418.104 Condition of participation: Clinical records. A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.</p> <p>(a) Standard: Content. Each patient's record must include the following:</p> <p>(1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.</p> <p>(2) Signed copies of the notice of patient rights in accordance with § 418.52 and election statement in accordance with § 418.24.</p> <p>(3) Responses to medications, symptom management, treatments, and services.</p> <p>(4) Outcome measure data elements, as described in § 418.54(e) of this subpart.</p> <p>(5) Physician certification and recertification of terminal illness as required in § 418.22 and § 418.25 and described in § 418.102(b) and § 418.102(c) respectively, if appropriate.</p> <p>(6) Any advance directives as described in § 418.52(a)(2).</p> <p>(7) Physician orders.</p> <p>(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.</p> <p>(c) Standard: Protection of information. The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use. The hospice must be in compliance with the Department's rules regarding personal health information as set out at 45 CFR parts 160 and 164.</p> <p>(d) Standard: Retention of records. Patient clinical records must be retained for 6 years after the death or discharge of the patient, unless State law stipulates</p>	<p>*481 I.A.C. 53.20(135J) Records. In accordance with accepted principles of medical record practice, each hospice shall maintain a centralized complete record on every individual receiving services. This record shall be preserved for at least three years following termination of services.</p> <p>53.20(1) Each entry shall be dated and signed, including the name and title of the person who makes the entry.</p> <p>53.20(2) The record shall include documentation of all services provided, whether furnished by the hospice or by contractual agreement. Each record shall include, but not be limited to:</p> <p><i>a.</i> Patient identification and demographic data;</p> <p><i>b.</i> Initial and subsequent assessments;</p> <p><i>c.</i> The plan of care;</p> <p><i>d.</i> Medical history;</p> <p><i>e.</i> Documentation of all services provided;</p> <p><i>f.</i> Consent and authorization forms;</p> <p><i>g.</i> Physicians' orders;</p> <p><i>h.</i> Medication records;</p> <p><i>i.</i> Discharge summary; and</p> <p><i>j.</i> Discharge and transfer records.</p> <p>53.20(3) The hospice shall have written and implemented policies to safeguard destruction or unauthorized use of patient records. Written procedures shall govern use and removal of records, conditions for release of information and identification by title of the person who may release records. These rules are intended to implement Iowa Code sections 135J.1 to 135J.6.</p> <p>135B.7A procedures - orders. The department shall adopt rules that require hospitals to establish procedures for authentication of all verbal orders by a practitioner within a period not to exceed thirty days following a patient's discharge.</p>

<p>a longer period of time. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform its State agency and its CMS Regional office where such clinical records will be stored and how they may be accessed.</p> <p>(e) Standard: Discharge or transfer of care.</p> <p>(1) If the care of a patient is transferred to another Medicare/ Medicaid-certified facility, the hospice must forward to the receiving facility, a copy of—</p> <ul style="list-style-type: none"> (i) The hospice discharge summary; and (ii) The patient’s clinical record, if requested. <p>(2) If a patient revokes the election of hospice care, or is discharged from hospice in accordance with § 418.26, the hospice must forward to the patient’s attending physician, a copy of—</p> <ul style="list-style-type: none"> (i) The hospice discharge summary; and (ii) The patient’s clinical record, if requested. <p>(3) The hospice discharge summary as required in paragraph (e)(1) and (e)(2) of this section must include—</p> <ul style="list-style-type: none"> (i) A summary of the patient’s stay including treatments, symptoms and pain management. (ii) The patient’s current plan of care. (iii) The patient’s latest physician orders. <p>and</p> <ul style="list-style-type: none"> (iv) Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility. <p>(f) Standard: Retrieval of clinical records. The clinical record, whether hard copy or in electronic form, must be made readily available on request by an appropriate authority.</p>	
<p>§ 418.106 Condition of participation: Drugs and biologicals, medical supplies, and durable medical equipment.</p> <p>Medical supplies and appliances, as described in § 410.36 of this chapter; durable medical equipment, as described in § 410.38 of this chapter; and drugs and biological related to the palliation and management of the terminal illness</p>	<p>657 I.A.C. 21.16 Facsimile transmission of Schedule II controlled substances— hospice patients.</p> <p>A prescription for a Schedule II controlled substance for a patient enrolled in a hospice care program licensed pursuant to Iowa Code chapter 135J or a program certified or paid for by Medicare under Title XVIII may be transmitted via</p>

and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care.

(a) Standard: Managing drugs and biologicals.

(1) The hospice must ensure that the interdisciplinary group confers with an individual with education and training in drug management as defined in hospice policies and procedures and State law, who is an employee of or under contract with the hospice to ensure that drugs and biologicals meet each patient's needs.

(2) A hospice that provides inpatient care directly in its own facility must provide pharmacy services under the direction of a qualified licensed pharmacist who is an employee of or under contract with the hospice. The provided pharmacist services must include evaluation of a patient's response to medication therapy, identification of potential adverse drug reactions, and recommended appropriate corrective action.

(b) Standard: Ordering of drugs.

(1) Only a physician as defined by section 1861(r)(1) of the Act, or a nurse practitioner in accordance with the plan of care and State law, may order drugs for the patient.

(2) If the drug order is verbal or given by or through electronic transmission—

(i) It must be given only to a licensed nurse, nurse practitioner (where appropriate), pharmacist, or physician; and

(ii) The individual receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with State and Federal regulations.

(c) Standard: Dispensing of drugs and biologicals.

The hospice must—

(1) Obtain drugs and biologicals from community or institutional pharmacists or stock drugs and biologicals itself.

(2) The hospice that provides inpatient care directly in its own facility must:

(i) Have a written policy in place that

facsimile by the practitioner or the practitioner's agent to the dispensing pharmacy.

21.16(1) Original prescription.

The facsimile serves as the original written prescription.

21.16(2) Information required.

The practitioner or the practitioner's agent shall note on the prescription that the patient is a hospice.

promotes dispensing accuracy;
and

(ii) Maintain current and accurate records of the receipt and disposition of all controlled drugs.

(d) Standard: Administration of drugs and biologicals.

(1) The interdisciplinary group, as part of the review of the plan of care, must determine the ability of the patient and/or family to safely self-administer drugs and biologicals to the patient in his or her home.

(2) Patients receiving care in a hospice that provides inpatient care directly in its own facility may only be administered medications by the following individuals:

(i) A licensed nurse, physician, or other health care professional in accordance with their scope of practice and State law;

(ii) An employee who has completed a State-approved training program in medication administration; and

(iii) The patient, upon approval by the interdisciplinary group.

(e) Standard: Labeling, disposing, and storing of drugs and biologicals.

(1) **Labeling.** Drugs and biologicals must be labeled in accordance with currently accepted professional practice and must include appropriate usage and cautionary instructions, as well as an expiration date (if applicable).

(2) **Disposing.**

(i) Safe use and disposal of controlled drugs in the patient's home. The hospice must have written policies and procedures for the management and disposal of controlled drugs in the patient's home. At the time when controlled drugs are first ordered the hospice must:

(A) Provide a copy of the hospice written policies and procedures on the management and disposal of controlled drugs to the patient or patient representative and family;

(B) Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that

they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; and

(C) Document in the patient's clinical record that the written policies and procedures for managing controlled drugs was provided and discussed.

(ii) Disposal of controlled drugs in hospices that provide inpatient care directly. The hospice that provides inpatient care directly in its own facility must dispose of controlled drugs in compliance with the hospice policy and in accordance with State and Federal requirements. The hospice must maintain current and accurate records of the receipt and disposition of all controlled drugs.

(3) **Storing.** The hospice that provides inpatient care directly in its own facility must comply with the following additional requirements—

(i) All drugs and biologicals must be stored in secure areas. All controlled drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1976 must be stored in locked compartments within such secure storage areas. Only personnel authorized to administer controlled drugs as noted in paragraph (d)(2) of this section may have access to the locked compartments; and

(ii) Discrepancies in the acquisition, storage, dispensing, administration, disposal, or return of controlled drugs must be investigated immediately by the pharmacist and hospice administrator and where required reported to the appropriate State authority. A written account of the investigation must be made available to State and Federal officials if required by law or regulation.

(f) Standard: Use and maintenance of equipment and supplies.

(1) The hospice must ensure that manufacturer recommendations for performing routine and preventive maintenance on durable medical equipment are followed. The equipment must be safe and work as intended for use in the patient's environment. Where a manufacturer

<p>recommendation for a piece of equipment does not exist, the hospice must ensure that repair and routine maintenance policies are developed. The hospice may use persons under contract to ensure the maintenance and repair of durable medical equipment.</p> <p>(2) The hospice must ensure that the patient, where appropriate, as well as the family and/or other caregiver(s), receive instruction in the safe use of durable medical equipment and supplies. The hospice may use persons under contract to ensure patient and family instruction. The patient, family, and/or caregiver must be able to demonstrate the appropriate use of durable medical equipment to the satisfaction of the hospice staff.</p> <p>(3) Hospices may only contract for durable medical equipment services with a durable medical equipment supplier that meets the Medicare DMEPOS Supplier Quality and Accreditation Standards at 42 CFR § 424.57.</p>	
<p>§ 418.108 Condition of participation: Short-term inpatient care. Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating Medicare or Medicaid facility.</p> <p>(a) Standard: Inpatient care for symptom management and pain control. Inpatient care for pain control and symptom management must be provided in one of the following:</p> <p>(1) A Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly as specified in § 418.110.</p> <p>(2) A Medicare-certified hospital or a skilled nursing facility that also meets the standards specified in § 418.110(b) and (e) regarding 24-hour nursing services and patient areas.</p> <p>(b) Standard: Inpatient care for respite purposes. (1) Inpatient care for respite purposes must be provided by one of the following:</p> <p>(i) A provider specified in paragraph (a)</p>	<p>*481 I.A.C. 53.18 (135J) Short-term hospital services. Each hospice shall have a written agreement with a local or area hospital which promotes continuation of the hospice plan of care and training for hospital staff who care for hospice patients. This rule is intended to implement Iowa Code section 135J.3(2).</p>

of this section.

(ii) A Medicare or Medicaid-certified nursing facility that also meets the standards specified in § 418.110(f).

(2) The facility providing respite care must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

(c) Standard: Inpatient care provided under arrangements. If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice, and at a minimum specifies—

(1) That the hospice supplies the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished;

(2) That the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients;

(3) That the hospice patient's inpatient clinical record includes a record of all inpatient services furnished and events regarding care that occurred at the facility; that a copy of the discharge summary be provided to the hospice at the time of discharge; and that a copy of the inpatient clinical record is available to the hospice at the time of discharge;

(4) That the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the agreement;

(5) That the hospice retains responsibility for ensuring that the training of personnel who will be providing the patient's care in the inpatient facility has been provided and that a description of the training and the names of those giving the training are documented; and

<p>(6) A method for verifying that the requirements in paragraphs (c)(1) through (c)(5) of this section are met.</p> <p>(d) Standard: Inpatient care limitation. The total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed 20 percent of the total number of hospice days consumed in total by this group of beneficiaries.</p> <p>(e) Standard: Exemption from limitation. Before October 1, 1986, any hospice that began operation before January 1, 1975, is not subject to the limitation specified in paragraph (d) of this section.</p>	
<p>§ 418.110 Condition of participation: Hospices that provide inpatient care directly.</p> <p>A hospice that provides inpatient care directly in its own facility must demonstrate compliance with all of the following standards:</p> <p>(a) Standard: Staffing. The hospice is responsible for ensuring that staffing for all services reflects its volume of patients, their acuity, and the level of intensity of services needed to ensure that plan of care outcomes are achieved and negative outcomes are avoided.</p> <p>(b) Standard: Twenty-four hour nursing services.</p> <p>(1) The hospice facility must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.</p> <p>(2) If at least one patient in the hospice facility is receiving general inpatient care, then each shift must include a registered nurse who provides direct patient care.</p> <p>(c) Standard: Physical environment. The hospice must maintain a safe physical environment free of hazards for patients, staff, and visitors.</p>	

(1) *Safety management.*

- (i) The hospice must address real or potential threats to the health and safety of the patients, others, and property.
- (ii) The hospice must have a written disaster preparedness plan in effect for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. The plan must be periodically reviewed and rehearsed with staff (including non-employee staff) with special emphasis placed on carrying out the procedures necessary to protect patients and others.

(2) *Physical plant and equipment.* The hospice must develop procedures for controlling the reliability and quality of—

- (i) The routine storage and prompt disposal of trash and medical waste;
- (ii) Light, temperature, and ventilation/air exchanges throughout the hospice;
- (iii) Emergency gas and water supply; and
- (iv) The scheduled and emergency maintenance and repair of all equipment.

(d) Standard: Fire protection.

(1) Except as otherwise provided in this section—

- (i) The hospice must meet the provisions applicable to nursing homes of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: <http://www.archives.gov/federalregister/codeoffederalregulations/ibrlocations.html>. Copies may

be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in the edition of the Code are incorporated by reference, CMS will publish a notice in the **Federal Register** to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospices.

(2) In consideration of a recommendation by the State survey agency, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied would result in unreasonable hardship for the hospice, but only if the waiver would not adversely affect the health and safety of patients.

(3) The provisions of the adopted edition of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in hospices.

(4) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a hospice may place alcohol-based hand rub dispensers in its facility if—

(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;

(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

(iii) The dispensers are installed in a manner that adequately protects against access by vulnerable populations; and

(iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the

Federal Register has approved NFPA Temporary Interim Amendment 00–1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/codeof_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in the edition of the Code are incorporated by reference, CMS will publish a notice in the **Federal Register** to announce the changes.

(e) Standard: Patient areas. The hospice must provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort, and privacy of patients.

(1) The hospice must provide—

- (i) Physical space for private patient and family visiting;
- (ii) Accommodations for family members to remain with the patient throughout the night; and
- (iii) Physical space for family privacy after a patient's death.

(2) The hospice must provide the opportunity for patients to receive visitors at any hour, including infants and small children.

(f) Standard: Patient rooms.

(1) The hospice must ensure that patient rooms are designed and equipped for nursing care, as well as the dignity, comfort, and privacy of patients.

(2) The hospice must accommodate a patient and family request for a single room whenever possible.

(3) Each patient's room must—

- (i) Be at or above grade level;
- (ii) Contain a suitable bed and other

<p>appropriate furniture for each patient;</p> <p>(iii) Have closet space that provides security and privacy for clothing and personal belongings;</p> <p>(iv) Accommodate no more than two patients and their family members;</p> <p>(v) Provide at least 80 square feet for each residing patient in a double room and at least 100 square feet for each patient residing in a single room; and</p> <p>(vi) Be equipped with an easily-activated, functioning device accessible to the patient, that is used for calling for assistance.</p> <p>(4) For a facility occupied by a Medicare-participating hospice on December 2, 2008, CMS may waive the space and occupancy requirements of paragraphs (f)(2)(iv) and (f)(2)(v) of this section if it determines that—</p> <p>(i) Imposition of the requirements would result in unreasonable hardship on the hospice if strictly enforced; or jeopardize its ability to continue to participate in the Medicare program; and</p> <p>(ii) The waiver serves the needs of the patient and does not adversely affect their health and safety.</p> <p>(g) Standard: Toilet and bathing facilities. Each patient room must be equipped with, or conveniently located near, toilet and bathing facilities.</p> <p>(h) Standard: Plumbing facilities. The hospice must—</p> <p>(1) Have an adequate supply of hot water at all times; and</p> <p>(2) Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients.</p> <p>(i) Standard: Infection control. The hospice must maintain an infection control program that protects patients, staff and others by preventing and controlling infections and communicable disease as stipulated in § 418.60.</p> <p>(j) Standard: Sanitary environment. The hospice must provide a sanitary environment by following current standards of practice, including nationally</p>	
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recognized infection control precautions, and avoid sources and transmission of infections and communicable diseases.

(k) Standard: Linen. The hospice must have available at all times a quantity of clean linen in sufficient amounts for all patient uses. Linens must be handled, stored, processed, and transported in such a manner as to prevent the spread of contaminants.

(l) Standard: Meal service and menu planning. The hospice must furnish meals to each patient that are—

(1) Consistent with the patient's plan of care, nutritional needs, and therapeutic diet;

(2) Palatable, attractive, and served at the proper temperature; and

(3) Obtained, stored, prepared, distributed, and served under sanitary conditions.

(m) Standard: Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

(1) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.

(2) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

(3) The use of restraint or seclusion must be—

(i) In accordance with a written modification to the patient's plan of care; and

(ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospice policy in accordance with State

law.

(4) The use of restraint or seclusion must be in accordance with the order of a physician authorized to order restraint or seclusion by hospice policy in accordance with State law.

(5) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

(6) The medical director or physician designee must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

(7) Unless superseded by State law that is more restrictive—

(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:

(A) 4 hours for adults 18 years of age or older;

(B) 2 hours for children and adolescents 9 to 17 years of age; or

(C) 1 hour for children under 9 years of age; and

After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician authorized to order restraint or seclusion by hospice policy in accordance with State law must see and assess the patient.

(ii) Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospice policy.

(4) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

(5) The condition of the patient who is restrained or secluded must be monitored by a physician or trained staff that have completed the training criteria specified in paragraph (n) of this

section at an interval determined by hospice policy.

(6) Physician, including attending physician, training requirements must be specified in hospice policy. At a minimum, physicians and attending physicians authorized to order restraint or seclusion by hospice policy in accordance with State law must have a working knowledge of hospice policy regarding the use of restraint or seclusion.

(7) When restraint or seclusion is used for the management of violent or self destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention—

(i) By a—

(A) Physician; or

(B) Registered nurse who has been trained in accordance with the requirements specified in paragraph (n) of this section.

(ii) To evaluate—

(A) The patient's immediate situation;

(B) The patient's reaction to the intervention;

(C) The patient's medical and behavioral condition; and

(D) The need to continue or terminate the restraint or seclusion.

(8) States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (m)(11)(i) of this section.

(9) If the face-to-face evaluation specified in § 418.110(m)(11) is conducted by a trained registered nurse, the trained registered nurse must consult the medical director or physician designee as soon as possible after the completion of the 1-hour face-to-face evaluation.

(10) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored—

(i) Face-to-face by an assigned, trained

staff member; or

(ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

(11) When restraint or seclusion is used, there must be documentation in the patient's clinical record of the following:

(i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;

(ii) A description of the patient's behavior and the intervention used;

(iii) Alternatives or other less restrictive interventions attempted (as applicable);

(iv) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and the patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

(n) Standard: Restraint or seclusion staff training requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff.

(1) *Training intervals.* All patient care staff working in the hospice inpatient facility must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion—

(i) Before performing any of the actions specified in this paragraph;

(ii) As part of orientation; and

(iii) Subsequently on a periodic basis consistent with hospice policy.

(2) *Training content.* The hospice must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

(i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.

(ii) The use of nonphysical intervention skills.

<p>(iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.</p> <p>(iv) The safe application and use of all types of restraint or seclusion used in the hospice, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).</p> <p>(v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.</p> <p>(vi) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospice policy associated with the 1-hour face-to-face evaluation.</p> <p>(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.</p> <p>(3) <i>Trainer requirements.</i> Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.</p> <p>(4) <i>Training documentation.</i> The hospice must document in the staff personnel records that the training and demonstration of competency were successfully completed.</p> <p>(o) Standard: Death reporting requirements. Hospices must report deaths associated with the use of seclusion or restraint.</p> <p>(1) The hospice must report the following information to CMS:</p> <p>(i) Each unexpected death that occurs while a patient is in restraint or seclusion.</p> <p>(ii) Each unexpected death that occurs within 24 hours after the patient has been removed from restraint or seclusion.</p> <p>(iii) Each death known to the hospice that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of</p>	
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<p>restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.</p> <p>(2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.</p> <p>(3) Staff must document in the patient's clinical record the date and time the death was reported to CMS.</p>	
<p>§ 418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/MR. In addition to meeting the conditions of participation at § 418.10 through § 418.116, a hospice that provides hospice care to residents of a SNF/NF or ICF/MR must abide by the following additional standards.</p> <p>(a) Standard: Resident eligibility, election, and duration of benefits. Medicare patients receiving hospice services and residing in a SNF, NF, or ICF/MR are subject to the Medicare hospice eligibility criteria set out at § 418.20 through § 418.30.</p> <p>(b) Standard: Professional management. The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to § 418.100 and § 418.108.</p> <p>(c) Standard: Written agreement. The hospice and SNF/NF or ICF/MR must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by authorized representatives of the hospice and the SNF/NF or ICF/MR before the provision of hospice services.</p>	<p>Iowa Code § 135C.32 Hospice services covered by Medicare.</p> <p>The requirement that the care of a resident of a health care facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:</p> <ol style="list-style-type: none"> 1. The resident is terminally ill. 2. The resident has elected to receive hospice services under the federal Medicare program from a Medicare certified hospice program. 3. The health care facility and the Medicare certified hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident. <p>Elder Group Homes:</p> <p>Iowa Code § 231B.2 Certification of elder group homes - rules.</p> <p>4. <i>a.</i> Services provided by a certified elder group home may be provided directly by staff of the elder group home, by individuals contracting with the elder group home to provide services, or by individuals employed by the tenant or with whom the tenant contracts if the tenant agrees to assume the responsibility and risk of the employment</p>

The written agreement must include at least the following:

- (1) The manner in which the SNF/NF or ICF/MR and the hospice are to communicate with each other and document such communications to ensure that the needs of patients are addressed and met 24 hours a day.
- (2) A provision that the SNF/NF or ICF/MR immediately notifies the hospice if—
 - (i) A significant change in a patient's physical, mental, social, or emotional status occurs;
 - (ii) Clinical complications appear that suggest a need to alter the plan of care;
 - (iii) A need to transfer a patient from the SNF/NF or ICF/MR, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related conditions; or
 - (iv) A patient dies.
- (3) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
- (4) An agreement that it is the SNF/ NF or ICF/MR responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected.
- (5) An agreement that it is the hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the SNF/NF or ICF/MR resident were in his or her own home.
- (6) A delineation of the hospice's responsibilities, which include, but are not limited to the following: Providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary and bereavement); social work; provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain

or the contractual relationship.

b. If a tenant is terminally ill and has elected to receive services under the federal Medicare program from a Medicare-certified program, the elder group home and the Medicare-certified program shall enter into a written agreement under which the program retains professional management responsibility for those services.

Assisted Living: Iowa Code § 231C.3

4. *a.* Services provided by a certified assisted living program may be provided directly by staff of the assisted living program, by individuals contracting with the assisted living program to provide services, or by individuals employed by the tenant or with whom the tenant contracts if the tenant agrees to assume the responsibility and risk of the employment or the contractual relationship.

b. If a tenant is terminally ill and has elected to receive services under the federal Medicare program from a Medicare-certified program, the assisted living program and the Medicare-certified program shall enter into a written agreement under which the program retains professional management responsibility for those services.

and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

(7) A provision that the hospice may use the SNF/NF or ICF/MR nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/ MR to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family in implementing the plan of care.

(8) A provision stating that the hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or ICF/MR administrator within 24 hours of the hospice becoming aware of the alleged violation.

(9) A delineation of the responsibilities of the hospice and the SNF/NF or ICF/MR to provide bereavement services to SNF/NF or ICF/ MR staff.

(d) Standard: Hospice plan of care.
 In accordance with § 418.56, a written hospice plan of care must be established and maintained In consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this hospice plan of care.

(1) The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.

(2) The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the extent possible.

(3) Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/MR representatives, and must be

approved by the hospice before implementation.

(e) Standard: Coordination of services.

The hospice must:
(1) Designate a member of each interdisciplinary group that is responsible for a patient who is a resident of a SNF/NF or ICF/MR. The designated interdisciplinary group member is responsible for:

(i) Providing overall coordination of the hospice care of the SNF/NF or ICF/ MR resident with SNF/NF or ICF/MR representatives; and
(ii) Communicating with SNF/NF or ICF/MR representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family.

(2) Ensure that the hospice IDG communicates with the SNF/NF or ICF/ MR medical director, the patient's attending physician, and other physicians participating in the provision of care to the patient as needed to coordinate the hospice care of the hospice patient with the medical care provided by other physicians.

(3) Provide the SNF/NF or ICF/MR with the following information:

(i) The most recent hospice plan of care specific to each patient;

(ii) Hospice election form and any advance directives specific to each patient;

(iii) Physician certification and recertification of the terminal illness specific to each patient;

(iv) Names and contact information for hospice personnel involved in hospice care of each patient;

(v) Instructions on how to access the hospice's 24-hour on-call system;

(vi) Hospice medication information specific to each patient; and

(vii) Hospice physician and attending physician (if any) orders specific to each patient.

(f) Standard: Orientation and training of staff.

Hospice staff must assure orientation of SNF/NF or ICF/MR

<p>staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.</p>	
<p>§ 418.114 Condition of participation: Personnel qualifications. (a) General qualification requirements. Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of his or her State license, or State certification, or registration. All personnel qualifications must be kept current at all times. (b) Personnel qualifications for certain disciplines. The following qualifications must be met: (1) Physician. Physicians must meet the qualifications and conditions as defined in section 1861(r) of the Act and implemented at § 410.20 of this chapter. (2) Hospice aide. Hospice aides must meet the qualifications required by section 1891(a)(3) of the Act and implemented at § 418.76. (3) Social worker. A person who— (i)(A) Has a Master of Social Work (MSW) degree from a school of social work accredited by the Council on Social Work Education; or (B) Has a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education; or a baccalaureate degree in psychology, sociology, or other field related to social work and is supervised by an MSW as described in paragraph (b)(3)(i)(A) of this section; and (ii) Has 1 year of social work experience in a healthcare setting; or (iii) Has a baccalaureate degree from a</p>	<p>Iowa Code § 147.2 LICENSE REQUIRED. A person shall not engage in the practice of medicine and surgery, podiatry, osteopathy, osteopathic medicine and surgery, psychology, chiropractic, physical therapy, nursing, dentistry, dental hygiene, optometry, speech pathology, audiology, occupational therapy, respiratory care, pharmacy, cosmetology, barbering, social work, dietetics, marital and family therapy or mental health counseling, massage therapy, mortuary science, athletic training, acupuncture, or sign language interpreting or transliterating, or shall not practice as a physician assistant as defined in the following chapters of this subtitle, unless the person has obtained from the department a license for that purpose. For purposes of this section, a person who is licensed in another state and recognized for licensure in this state pursuant to the nurse licensure compact contained in section 152E.1 or pursuant to the advanced practice registered nurse compact contained in section 152E.3 shall be considered to have obtained a license to practice nursing from the department.</p> <p>Physicians: Iowa Code § 148.3 Requirements for license. An applicant for a license to practice medicine and surgery shall: 1. Present a diploma issued by a medical college approved by the board, or present other evidence of equivalent medical education approved by the board. The board may accept, in lieu of a diploma from a medical college approved by them, all of the following: a. A diploma issued by a medical</p>

school of social work accredited by the Council on Social Work Education, is employed by the hospice before December 2, 2008, and is not required to be supervised by an MSW.

(4) **Speech language pathologist.** A person who meets either of the following requirements:

(i) The education and experience requirements for a Certificate of Clinical Competence in speech-language pathology granted by the American Speech-Language-Hearing Association.

(ii) The educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

(5) **Occupational therapist.** A person who—

(i) (A) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing, unless licensure does not apply; (B) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA), or successor organizations of ACOTE; and (C) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

(ii) On or before December 31, 2009—

(A) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing; Or (B) When licensure or other regulation does not apply—

(1) Graduated after successful completion of an occupational therapist education program accredited by the accreditation Council for Occupational therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or successor organizations of ACOTE; and

(2) Is eligible to take, or has successfully

college which has been neither approved nor disapproved by the board.

b. A valid standard certificate issued by the educational commission for foreign medical graduates or similar accrediting agency.

2. Pass an examination prescribed by the board which shall include subjects which determine the applicant's qualifications to practice medicine and surgery and which shall be given according to the methods deemed by the board to be the most appropriate and practicable. However, the federation licensing examination or any other national standardized examination which the board approves may be administered to any or all applicants in lieu of or in conjunction with other examinations which the board prescribes. The board may establish necessary achievement levels on all examinations for a passing grade and adopt rules relating to examinations.

3. Present to the board satisfactory evidence that the applicant has successfully completed one year of postgraduate internship or resident training in a hospital approved for such training by the board. Beginning July 1, 2006, an applicant who holds a valid certificate issued by the educational commission for foreign medical graduates shall submit satisfactory evidence of successful completion of two years of such training.

"Social services" are services provided by someone who has a bachelor's or higher degree in social work. (481 I.A.C. 53.1)

Social Worker:

Iowa Code § 154C.2 License required - exception - use of title.

1. A person shall not engage in the practice of social work unless the person is licensed pursuant to this chapter. A person who is not licensed pursuant to this chapter shall not use words or titles which imply or represent that the person is a licensed bachelor social worker,

<p>completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc., (NBCOT).</p> <p>(iii) On or before January 1, 2008— (A) Graduated after successful completion of an occupational therapy program accredited jointly by the committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association; or (B) Is eligible for the National Registration Examination of the American Occupational Therapy Association or the National Board for Certification in Occupational Therapy.</p> <p>(iv) On or before December 31, 1977— (A) Had 2 years of appropriate experience as an occupational therapist; and (B) Had achieved a satisfactory grade on an occupational therapist proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.</p> <p>(v) If educated outside the United States— (A) Must meet both of the following: (1) Graduated after successful completion of an occupational therapist education program accredited as substantially equivalent to occupational therapist assistant entry level education in the United States by one of the following: (i) The Accreditation Council for Occupational Therapy Education (ACOTE). (ii) Successor organizations of ACOTE. (iii) The World Federation of Occupational Therapists. (iv) A credentialing body approved by the American Occupational Therapy Association. (v) Successfully completed the entry level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).</p>	<p>licensed master social worker, or licensed independent social worker.</p> <p>2. Notwithstanding subsection 1, persons trained as bachelor social workers, or employed as bachelor social workers, are not required to be licensed.</p> <p>3. Section 147.83 does not apply to persons who are not licensed as bachelor social workers and who do not hold themselves out as licensed bachelor social workers.</p> <p>154C.3 Requirements to obtain license or reciprocal license - license renewal - continuing education.</p> <p>1. <i>License requirements.</i> An applicant for a license as a bachelor social worker, master social worker, or independent social worker shall meet the following requirements in addition to paying all fees required by the board:</p> <p><i>a. Bachelor social worker.</i> An applicant for a license as a bachelor social worker shall present evidence satisfactory to the board that the applicant:</p> <p>(1) Possesses a bachelor's degree in social work from an accredited college or university approved by the board. (2) Has passed an examination given by the board. (3) Will conduct all professional activities as a bachelor social worker in accordance with standards for professional conduct established by the board.</p> <p><i>b. Master social worker.</i> An applicant for a license as a master social worker shall present evidence satisfactory to the board that the applicant:</p> <p>(1) Possesses a master's or doctoral degree in social work from an accredited college or university approved by the board. (2) Has passed an examination given by the board. (3) Will conduct all professional activities as a master social worker in accordance with standards for professional conduct established by the board.</p> <p><i>c. Independent social worker.</i> An applicant for a license as an independent social worker shall present evidence satisfactory to the board that the</p>
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<p>(2) On or before December 31, 2009, is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing.</p> <p>(6) Occupational therapy assistant. A person who (i) Meets all of the following:</p> <p>(A) Is licensed or otherwise regulated, if applicable, as an occupational therapy assistant by the State in which practicing, unless licensure does apply.</p> <p>(B) Graduated after successful completion of an occupational therapy assistant education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or its successor organizations.</p> <p>(C) Is eligible to take or successfully completed the entry level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).</p> <p>(ii) On or before December 31, 2009—</p> <p>(A) Is licensed or otherwise regulated as an occupational therapy assistant, if applicable, by the State in which practicing; or any qualifications defined by the State in which practicing, unless licensure does not apply; or</p> <p>(B) Must meet both of the following:</p> <p>(1) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy Association.</p> <p>(2) After January 1, 2010, meets the requirements in paragraph (b)(6)(i) of this section.</p> <p>(iii) After December 31, 1977 and on or before December 31, 2007—</p> <p>(A) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy Association; or</p> <p>(B) Completed the requirements to</p>	<p>applicant:</p> <p>(1) Possesses a master's or doctoral degree in social work from an accredited college or university approved by the board.</p> <p>(2) Has passed an examination given by the board.</p> <p>(3) Will conduct all professional activities as a social worker in accordance with standards for professional conduct established by the board.</p> <p>(4) Has engaged in the practice of social work, under supervision, for at least two years as a full-time employee or for four thousand hours prior to taking the examination given by the board.</p> <p>(5) Supervision shall be provided in any of the following manners:</p> <p>(a) By a social worker licensed at least at the level of the social worker being supervised and qualified under this section to practice without supervision.</p> <p>(b) By another qualified professional, if the board determines that supervision by a social worker as defined in subparagraph subdivision (a) is unobtainable or in other situations considered appropriate by the board.</p> <p>Additional standards for supervision shall be determined by the board.</p> <p>2. <i>Reciprocal license.</i> The board shall issue an appropriate license to an applicant licensed to practice social work in another state which imposes licensure requirements similar or equal to those imposed under subsection 1.</p> <p>3. <i>License renewal and continuing education.</i> Licenses shall be renewed biennially, and licensees shall pay a fee for renewal as determined by the board and shall present evidence satisfactory to the board that the licensee has satisfied continuing education requirements as determined by the board.</p> <p>Occupational Therapist & Occupational Therapist Assistant Iowa Code §148B.5 Requirements for licensure.</p> <p>An applicant applying for a license as an occupational therapist or as an occupational therapy assistant must file a</p>
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<p>practice as an occupational therapy assistant applicable in the State in which practicing.</p> <p>(iv) On or before December 31, 1977—</p> <p>(A) Had 2 years of appropriate experience as an occupational therapy assistant; and</p> <p>(B) Had achieved a satisfactory grade on an occupational therapy assistant proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.</p> <p>(v) If educated outside the United States, on or after January 1, 2008—</p> <p>(A) Graduated after successful completion of an occupational therapy assistant education program that is accredited as substantially equivalent to occupational therapist assistant entry level education in the United States by—</p> <p>(1) The Accreditation Council for Occupational Therapy Education (ACOTE).</p> <p>(2) Its successor organizations.</p> <p>(3) The World Federation of Occupational Therapists.</p> <p>(4) By a credentialing body approved by the American Occupational Therapy Association; and</p> <p>(5) Successfully completed the entry level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).</p> <p>(7) Physical therapist. A person who is licensed, if applicable, by the State in which practicing, unless licensure does not apply and meets one of the following requirements:</p> <p>(A) Graduated after successful completion of a physical therapist education program approved by one of the following:</p> <p>(B) The Commission on Accreditation in Physical Therapy Education (CAPTE).</p> <p>(C) Successor organizations of CAPTE.</p> <p>(D) An education program outside the United States determined to be substantially equivalent to physical</p>	<p>written application on forms provided by the board, showing to the satisfaction of the board that the applicant meets the following requirements:</p> <ol style="list-style-type: none"> 1. Successful completion of the academic requirements of an educational program in occupational therapy recognized by the board. <ol style="list-style-type: none"> a. For an occupational therapist, the program must be one accredited by the accreditation council for occupational therapy education of the American occupational therapy association. b. For an occupational therapy assistant, the program must be one approved by the American occupational therapy association. 2. Successful completion of a period of supervised field work experience at a recognized educational institution or a training program approved by the educational institution where the applicant met the academic requirements. <ol style="list-style-type: none"> a. For an occupational therapist a minimum of six months of supervised field work experience is required. b. For an occupational therapy assistant, a minimum of two months of supervised field work experience is required. 3. Pass an examination, either in electronic or written form, satisfactory to the board and in accordance with rules. <p>148B.3 Persons and practices not affected.</p> <p>This chapter does not prevent or restrict the practice, services or activities of any of the following:</p> <ol style="list-style-type: none"> 1. A person licensed in this state by any other law from engaging in the profession or occupation for which the person is licensed. 2. A person employed as an occupational therapist or occupational therapy assistant by the government of the United States, if that person provides occupational therapy solely under the direction or control of the organization by which the person is employed. 3. A person pursuing a course of study leading to a degree or certificate in occupational therapy in an accredited or
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<p>therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or an organization identified in 8 CFR 212.15(e) as it relates to physical therapists.</p> <p>(E) Passed an examination for physical therapists approved by the State in which physical therapy services are provided.</p> <p>(i) On or before December 31, 2009—</p> <p>(A) Graduated after successful completion of a physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy Education (CAPTE);</p> <p>Or (B) Meets both of the following:</p> <p>(1) Graduated after successful completion of an education program determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified in 8 CFR 212.15(e) as it relates to physical therapists.</p> <p>(2) Passed an examination for physical therapists approved by the State in which physical therapy services are provided.</p> <p>(ii) Before January 1, 2008—</p> <p>(A) Graduated from a physical therapy curriculum approved by one of the following:</p> <p>(1) The American Physical Therapy Association.</p> <p>(2) The Committee on Allied Health Education and Accreditation of the American Medical Association.</p> <p>(3) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association.</p> <p>(iii) On or before December 31, 1977 was licensed or qualified as a physical therapist and meets both of the following:</p> <p>(A) Has 2 years of appropriate experience as a physical therapist.</p> <p>(B) Has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S.</p>	<p>approved educational program, if the activities and services constitute a part of a supervised course of study and the person is designated by a title which clearly indicates the person's status as a student or trainee.</p> <p>4. A person fulfilling the supervised field work experience requirements of section 148B.5 , if the activities and services constitute a part of the experience necessary to meet the requirements of that section.</p> <p>5. A nonresident performing occupational therapy services in this state who is not licensed under this chapter, if the services are performed for not more than thirty days a calendar year in association with an occupational therapist licensed under this chapter, and the nonresident meets the qualifications for licensing under this chapter except for the qualifying examination.</p> <p>6. A nonresident performing occupational therapy services in the state who is not licensed under this chapter, if the services are performed for not more than ninety days in a calendar year in association with an occupational therapist licensed under this chapter, and</p> <p>a. The nonresident is licensed under the law of another state which has licensure requirements at least as stringent as the requirements of this chapter, or</p> <p>b. The nonresident meets the requirements for certification as an occupational therapist registered (O.T.R.), or a certified occupational therapy assistant (C.O.T.A.) established by the American occupational therapy association.</p> <p>Physical Therapy 148A.4 Requirements to practice. Each applicant for a license to practice physical therapy shall:</p> <p>1. Complete a course of study in, and hold a diploma or certificate issued by, a school of physical therapy accredited by the American physical therapy association or another appropriate</p>
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<p>Public Health Service.</p> <p>(iv) Before January 1, 1966—</p> <p>(A) Was admitted to membership by the American Physical Therapy Association;</p> <p>(B) Was admitted to registration by the American Registry of Physical Therapists; and (C) Graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education.</p> <p>(vi) Before January 1, 1966 was licensed or registered, and before January 1, 1970, had 15 years of fulltime experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy.</p> <p>(vii) If trained outside the United States before January 1, 2008, meets the following requirements:</p> <p>(A) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy.</p> <p>(B) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.</p> <p>(8) Physical therapist assistant. A person who is licensed, registered or certified as a physical therapist assistant, if applicable, by the State in which practicing, unless licensure does not apply and meets one of the following requirements:</p> <p>(i) Graduated from a physical therapist assistant curriculum approved by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association; or if educated outside the United States or trained in the United States military, graduated from an education program determined to be substantially equivalent to physical therapist assistant entry level education in the United States by a credentials</p>	<p>accrediting body, and meet requirements as established by rules of the board.</p> <p>2. Have passed an examination administered by the board.</p> <p>148A.3 Persons not included.</p> <p>Section 148A.1 shall not be construed to include the following classes of persons:</p> <p>1. Licensed physicians and surgeons, osteopaths, osteopathic physicians and surgeons, podiatric physicians, chiropractors, nurses, dentists, cosmetologists, and barbers, who are engaged in the practice of their respective professions.</p> <p>2. Students of physical therapy who practice physical therapy under the supervision of a licensed physical therapist in connection with the regular course of instruction at a school of physical therapy.</p> <p>3. Physical therapists of the United States army, navy, or public health service, or physical therapists licensed in another state, when incidentally called into this state in consultation with a physician and surgeon or physical therapists licensed in this state.</p> <p>4. Nonprofessional workers not held out as physical therapists who are employed in hospitals, clinics, offices or health care facilities as defined in section 135C.1 working under the supervision and direction of a physical therapist or physician licensed pursuant to chapter 148 , 150 or 150A .</p> <p>5. Massage therapists, massage technicians, masseurs and masseuses who administer body massage by Swedish or other massage technique, including modalities, in a massage establishment, health club, athletic club or school athletic department, but in no instance shall they designate themselves as physical therapists.</p> <p>Iowa Code § 148A.6 Physical therapist assistant.</p> <p>1. A licensed physical therapist assistant is required to function under the direction and supervision of a licensed physical therapist to perform physical therapy procedures delegated</p>
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<p>evaluation organization approved by the American Physical Therapy Association or identified at 8 CFR 212.15(e); and (ii) Passed a national examination for physical therapist assistants.</p> <p>(A) On or before December 31, 2009, meets one of the following:</p> <p>(1) Is licensed, or otherwise regulated in the State in which practicing.</p> <p>(2) In States where licensure or other regulations do not apply, graduated before December 31, 2009, from a 2-year college-level program approved by the American Physical Therapy Association and after January 1, 2010, meets the requirements of paragraph (b)(8) of this section.</p> <p>(3) Before January 1, 2008, where licensure or other regulation does not apply, graduated from a 2-year college level program approved by the American Physical Therapy Association.</p> <p>(4) On or before December 31, 1977, was licensed or qualified as a physical therapist assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.</p> <p>(c) Personnel qualifications when no State licensing, certification or registration requirements exist. If no State licensing laws, certification or registration requirements exist for the profession, the following requirements must be met:</p> <p>(1) <i>Registered nurse.</i> A graduate of a school of professional nursing.</p> <p>(2) <i>Licensed practical nurse.</i> A person who has completed a practical nursing program.</p> <p>(d) Standard: Criminal background checks.</p> <p>(1) The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient</p>	<p>and supervised by the licensed physical therapist in a manner consistent with the rules adopted by the board. Selected and delegated tasks of physical therapist assistants may include but are not limited to therapeutic procedures and related tasks, routine operational functions, documentation of treatment progress, and the use of selected physical agents. The ability of the licensed physical therapist assistant to perform the selected and delegated tasks shall be assessed on an ongoing basis by the supervising physical therapist. The licensed physical therapist assistant shall not interpret referrals, perform initial evaluation or reevaluations, initiate physical therapy treatment programs, change specified treatment programs, or discharge a patient from physical therapy services.</p> <p>2. Each applicant for a license to practice as a physical therapist assistant shall:</p> <p>a. Successfully complete a course of study for the physical therapist assistant accredited by the commission on accreditation in education of the American physical therapy association, or another appropriate accrediting body, and meet other requirements established by the rules of the board.</p> <p>b. Have passed an examination administered by the board.</p> <p>3. This section does not prevent a person not licensed as a physical therapist assistant from performing services ordinarily performed by a physical therapy aide, assistant, or technician, provided that the person does not represent to the public that the person is a licensed physical therapist assistant, or use the title "physical therapist assistant" or the letters "P.T.A.", and provided that the person performs services consistent with the supervision requirements of the board for persons not licensed as physical therapist assistants.</p> <p>481 I.A.C. 50.9 Background checks. Beginning July 1, 1988, each home health agency or hospice that is</p>
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contact or access to patient records.
(2) Criminal background checks must be obtained in accordance with State requirements. In the absence of State requirements, criminal background checks must be obtained within three months of the date of employment

regulated by the state or receives any state or federal funding shall submit a form specified by the department of public safety to the department of public safety and receive the results of a criminal history check and dependent adult abuse record check before any person is employed by the home health agency or hospice. The home health agency or hospice may submit a form specified by the department of human services to the department of human services to request a child abuse history check.

For the purposes of this rule, "employed in or by a home health agency or hospice" shall be defined as any individual who is paid, either by the home health agency, hospice or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractor) to provide direct or indirect treatment or services to patients of the home health agency or hospice. Direct treatment or services include those provided through person-to-person contact. Indirect treatment or services include, but are not limited to, person-to-person contact services provided by administration, homemaker aides, and assistants.

50.9(1)

A person who has a criminal record or founded dependent adult abuse report cannot be employed in a home health agency or hospice unless the department of human services has evaluated the crime or founded abuse report and concluded that the crime or founded abuse report does not merit prohibition from employment.

50.9(2)

Each home health agency or hospice shall ask each person seeking employment by the home health agency or hospice, "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime in this state or any other state?" The person shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The person shall indicate, by signature,

that the person has been informed that the record checks will be conducted.

50.9(3)

If a person has a record of founded child abuse in Iowa or any other state, the person shall not be employed by a home health agency or hospice unless the department of human services has evaluated the crime or founded abuse report and concluded that the report does not merit prohibition of employment.

50.9(4)

Proof of dependent adult abuse and criminal history checks may be kept in files maintained by the temporary employment agencies and contractors. Home health agencies and hospices may require temporary agencies and contractors to provide a copy of the results of dependent adult abuse and criminal history checks.

50.9(5)

The results of a records check shall be valid for a period of 30 days from the date it was requested during which time the facility may determine whether the potential employee is to be hired.

For Hospitals, Nursing Facilities, and others: Senate File 2425 passed in 2008—effective July 1, 2008:

135B.34 HOSPITAL EMPLOYEES == CRIMINAL HISTORY AND ABUSE RECORD CHECKS == PENALTY.

1. Prior to employment of a person in a hospital, the hospital shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. A hospital shall inform all persons prior to employment regarding the performance of the records checks and shall obtain, from the persons, a signed acknowledgment of the receipt of the information. A hospital shall include the following inquiry in an application for employment: "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a

	<p>crime, in this state or any other state?"</p> <p>2. a. If it is determined that a person being considered for employment in a hospital has committed a crime, the department of public safety shall notify the hospital that upon the request of the hospital the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the hospital.</p> <p>b. If a department of human services child or dependent adult abuse record check shows that the person has a record of founded child or dependent adult abuse, the department of human services shall notify the hospital that upon the request of the hospital the department of human services will perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of the person's employment in the hospital.</p> <p>c. An evaluation performed under this subsection shall be performed in accordance with procedures adopted for this purpose by the department of human services.</p> <p>d. (1) If a person owns or operates more than one hospital, and an employee of one of such hospitals is transferred to another such hospital without a lapse in employment, the hospital is not required to request additional criminal and child and dependent adult abuse records checks of that employee.</p> <p>(2) If the ownership of a hospital is transferred, at the time of transfer the records checks required by this section shall be performed for each employee for whom there is no documentation that such records checks have been performed. The hospital may continue to employ such employee pending the performance of the records checks and any related evaluation.</p> <p>3. In an evaluation, the department of human services shall consider the nature and seriousness of the crime or founded child or dependent adult abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded child or dependent</p>
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	<p>adult abuse, the circumstances under which the crime or founded child or dependent adult abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded child or dependent adult abuse again, and the number of crimes or founded child or dependent adult abuses committed by the person involved. If the department of human services performs an evaluation for the purposes of this section, the department of human services has final authority in determining whether prohibition of the person's employment is warranted.</p> <p>4. a. Except as provided in paragraph "b" and subsection 2, a person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a hospital licensed under this chapter unless an evaluation has been performed by the department of human services.</p> <p>b. A person with a criminal or abuse record who is employed by a hospital licensed under this chapter and is hired by another licensee without a lapse in employment shall be subject to the criminal history and abuse record checks required pursuant to subsection 1. If an evaluation was previously performed by the department of human services concerning the person's criminal or abuse record and it was determined that the record did not warrant prohibition of the person's employment and the latest record checks do not indicate a crime was committed or founded abuse record was entered subsequent to that evaluation, the person may commence employment with the other licensee while the department of human services' evaluation of the latest record checks is pending. Otherwise, the requirements of paragraph "a" remain applicable to the person's employment.</p> <p>5. a. If a person employed by a hospital that is subject to this section is convicted of a crime or has a record of founded child or dependent adult abuse entered in the abuse registry after the person's employment application date, the person shall inform the hospital of such</p>
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	<p>information within forty=eight hours of the criminal conviction or entry of the record of founded child or dependent adult abuse. The hospital shall act to verify the information within forty=eight hours of notification. If the information is verified, the requirements of subsections 2, 3, and 4 regarding employability and evaluations shall be applied by the hospital to determine whether or not the person's employment is continued. The hospital may continue to employ the person pending the performance of an evaluation by the department of human services to determine whether prohibition of the person's employment is warranted. A person who is required by this subsection to inform the person's employer of a conviction or entry of an abuse record and fails to do so within the required period commits a serious misdemeanor.</p> <p>b. If a hospital receives credible information, as determined by the hospital, that a person employed by the hospital has been convicted of a crime or a record of founded child or dependent adult abuse has been entered in the abuse registry after employment from a person other than the employee and the employee has not informed the hospital of such information within the period required under paragraph "a", the hospital shall act to verify the credible information within forty=eight hours of receipt of the credible information. If the information is verified, the requirements of subsections 2, 3, and 4 regarding employability and evaluations shall be applied by the hospital to determine whether or not the person's employment is continued.</p> <p>c. The hospital may notify the county attorney for the county where the hospital is located of any violation or failure by an employee to notify the hospital of a criminal conviction or entry of an abuse record within the period required under paragraph "a".</p> <p>6. A hospital licensed in this state may access the single contact repository established by the department pursuant to section 135C.33 as necessary for the</p>
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	<p>hospital to perform record checks of persons employed or being considered for employment by the hospital.</p> <p>Section 135C.33, Code 2007, is amended to read as follows:</p> <p>135C.33 EMPLOYEES == CHILD OR DEPENDENT ADULT ABUSE INFORMATION AND CRIMINAL RECORD CHECKS == EVALUATIONS == APPLICATION TO OTHER PROVIDERS == PENALTY. (Effective July 1, 2008)</p> <p>1. Prior to employment of a person in a facility, the facility shall request that the department of public safety perform a criminal history check and the department of human services perform a child and dependent adult abuse record checks of the person in this state. A facility shall inform all persons prior to employment regarding the performance of the records checks and shall obtain, from the persons, a signed acknowledgment of the receipt of the information. A facility shall include the following inquiry in an application for employment: "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime, in this state or any other state?"</p> <p>2. a. If it is determined that a person being considered for employment in a facility has been convicted of a crime under a law of any state, the department of public safety shall notify the licensee that upon the request of the licensee the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the facility.</p> <p>b. If a department of human services child or dependent adult abuse record check shows that such person has a record of founded child or dependent adult abuse, the department of human services shall notify the licensee that upon the request of the licensee the department of human services will perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the facility.</p>
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	<p>c. An evaluation performed under this subsection shall be performed in accordance with procedures adopted for this purpose by the department of human services.</p> <p>d. (1) If a person owns or operates more than one facility, and an employee of one of such facilities is transferred to another such facility without a lapse in employment, the facility is not required to request additional criminal and child and dependent adult abuse record checks of that employee.</p> <p>(2) If the ownership of a facility is transferred, at the time of transfer the records checks required by this section shall be performed for each employee for whom there is no documentation that such records checks have been performed. The facility may continue to employ such employee pending the performance of the records checks and any related evaluation.</p> <p>3. In an evaluation, the department of human services shall consider the nature and seriousness of the crime or founded child or dependent adult abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded child or dependent adult abuse, the circumstances under which the crime or founded child or dependent adult abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded child or dependent adult abuse again, and the number of crimes or founded child or dependent adult abuses committed by the person involved. If the department of human services performs an evaluation for the purposes of this section, the department of human services has final authority in determining whether prohibition of the person's employment is warranted.</p> <p>4. a. Except as provided in paragraph "b" and subsection 2, a person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a facility licensed under this chapter unless an evaluation has been performed by the</p>
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	<p>department of human services.</p> <p>b. A person with a criminal or abuse record who is employed by a facility licensed under this chapter and is hired by another licensee without a lapse in employment shall be subject to the criminal history and abuse record checks required pursuant to subsection 1. If an evaluation was previously performed by the department of human services concerning the person's criminal or abuse record and it was determined that the record did not warrant prohibition of the person's employment and the latest record checks do not indicate a crime was committed or founded abuse record was entered subsequent to that evaluation, the person may commence employment with the other licensee while the department of human services' evaluation of the latest record checks is pending. Otherwise, the requirements of paragraph "a" remain applicable to the person's employment.</p> <p>5. a. This section shall also apply to prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding:</p> <ul style="list-style-type: none">(1) An employee of a homemaker, home=health aide, home=care aide, adult day services, or other provider of in=home services if the employee provides direct services to consumers.(2) An employee of a hospice, if the employee provides direct services to consumers.(3) An employee who provides direct services to consumers under a federal home and community=based services waiver.(4) An employee of an elder group home certified under chapter 231B, if the employee provides direct services to consumers.(5) An employee of an assisted living program certified under chapter 231C, if the employee provides direct services to consumers. <p>b. In substantial conformance with the provisions of this section, prior to the employment of such an employee, the provider shall request the performance of</p>
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	<p>the criminal and child and dependent adult abuse record checks. The provider shall inform the prospective employee and obtain the prospective employee's signed acknowledgment. The department of human services shall perform the evaluation of any criminal record or founded child or dependent adult abuse record and shall make the determination of whether a prospective employee of a provider shall not be employed by the provider.</p> <p>6. a. The department of inspections and appeals, in conjunction with other departments and agencies of state government involved with criminal history and abuse registry information, shall establish a single contact repository for facilities and other providers to have electronic access to data to perform background checks for purposes of employment, as required of the facilities and other providers under this section.</p> <p>b. The department may access the single contact repository for any of the following purposes:</p> <ul style="list-style-type: none">(1) To verify data transferred from the department's nurse aide registry to the repository.(2) To conduct record checks of applicants for employment with the department. <p>7. a. If a person employed by a facility, service, or program employer that is subject to this section is convicted of a crime or has a record of founded child or dependent adult abuse entered in the abuse registry after the person's employment application date, the person shall inform the employer of such information within forty-eight hours of the criminal conviction or entry of the record of founded child or dependent adult abuse. The employer shall act to verify the information within forty-eight hours of notification. If the information is verified, the requirements of subsections 2, 3, and 4 regarding employability and evaluations shall be applied by the employer to determine whether or not the person's employment is continued. The employer may continue</p>
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	<p>to employ the person pending the performance of an evaluation by the department of human services to determine whether prohibition of the person's employment is warranted. A person who is required by this subsection to inform the person's employer of a conviction or entry of an abuse record and fails to do so within the required period commits a serious misdemeanor.</p> <p>b. If a facility, service, or program employer receives credible information, as determined by the employer, that a person employed by the employer has been convicted of a crime or a record of founded child or dependent adult abuse has been entered in the abuse registry after employment from a person other than the employee and the employee has not informed the employer of such information within the period required under paragraph "a", the employer shall act to verify the credible information within forty-eight hours of receipt of the credible information. If the information is verified, the requirements of subsections 2, 3, and 4 regarding employability and evaluations shall be applied to determine whether or not the person's employment is continued.</p> <p>c. The employer may notify the county attorney for the county where the employer is located of any violation or failure by an employee to notify the employer of a criminal conviction or entry of an abuse record within the period required under paragraph "a".</p>
<p>§ 418.116 Condition of participation: Compliance with Federal, State, and local laws and regulations related to the health and safety of patients. The hospice and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations related to the health and safety of patients. If State or local law provides for licensing of hospices, the hospice must be licensed. (a) Standard: Multiple locations.</p>	<p>*LICENSES -- FEES -- CRITERIA. A person or governmental unit, acting severally or jointly with any other person may establish, conduct, or maintain a hospice program in this state and receive a license from the department after meeting the requirements of this chapter. The application shall be on a form prescribed by the department and shall require information the department deems necessary. Nothing in this chapter shall prohibit a person or</p>

Every hospice must comply with the requirements of § 420.206 of this chapter regarding disclosure of ownership and control information. All hospice multiple locations must be approved by Medicare and licensed in accordance with State licensure laws, if applicable, before providing Medicare reimbursed services.

(b) Standard: Laboratory services.

- (1) If the hospice engages in laboratory testing other than assisting a patient in self-administering a test with an appliance that has been approved for that purpose by the FDA, the hospice must be in compliance with all applicable requirements of part 493 of this chapter.
- (2) If the hospice chooses to refer specimens for laboratory testing to a reference laboratory, the reference laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the applicable requirements of part 493 of this chapter.

governmental unit from establishing, conducting, or maintaining a hospice program without a license. Each application for license shall be accompanied by a nonrefundable biennial license fee determined by the department.

The hospice program shall meet the criteria pursuant to section 135J.3 before a license is issued. The department of inspections and appeals is responsible to provide the necessary personnel to inspect the hospice program, the home care and inpatient care provided and the hospital or facility used by the hospice to determine if the hospice complies with necessary standards before a license is issued.

Hospices that are certified as Medicare hospice providers by the department of inspections and appeals or are accredited as hospices by the joint commission on the accreditation of health care organizations, shall be licensed without inspection by the department of inspections and appeals. (Iowa Code §135J.2)

***481 I.A.C. 53.2 License.**

Application for an initial or renewal license may be obtained from the Department of Inspections and Appeals, Division of Health Facilities, Lucas State Office Building, Des Moines, Iowa 50319.

53.2(1) Prior to the issuance of a license each hospice must meet all the requirements set forth in this chapter.

53.2(2) The applicant shall submit a nonrefundable biennial license fee of \$500. If a license lapses for failure to make timely application for renewal, an additional 25 percent is required.

53.2(3) Each hospice seeking licensure is surveyed before the initial license is issued and biennially before a license is renewed.

53.2(4) Home care provider and inpatient facilities used by the hospice shall be inspected by the department to determine whether hospice regulations are met.

53.2(5) Hospices certified as Medicare providers by the department or

	<p>accredited by the Joint Commission on the Accreditation of Health Organizations will be licensed without inspection.</p> <p>53.2(6) The department may not prohibit any entity from establishing or maintaining a hospice without a license.</p> <p>53.2(7) The department may deny, suspend or revoke a license if the department finds that a hospice does not comply with these rules.</p> <p>53.2(8) A license is issued only for the premises, person, hospital or facility named on the application. The license may not be transferred or assigned to another person or entity.</p> <p>53.2(9) A license expires two years after the date issued unless it is suspended or revoked before that date. This rule is intended to implement Iowa Code sections 135J.2 and 135J.4 to 135J.6.</p>
<p>Subpart F--Covered Services</p>	
<p>§ 418.200 Requirements for coverage. To be covered, hospice services must meet the following requirements. They must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. The individual must elect hospice care in accordance with Sec. 418.24 and a plan of care must be established as set forth in Sec. 418.56 before Services are provided. The services must be consistent with the plan of care. A certification that the individual is terminally ill must be completed as set forth in Sec. 418.22.</p>	
<p>§ 418.202 Covered services. All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:</p>	

(a) Nursing care provided by or under the supervision of a registered nurse.

(b) Medical social services provided by a social worker under the direction of a physician.

(c) Physicians' services performed by a physician as defined in Sec. 410.20 of this chapter except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.

(d) Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.

(e) Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or SNF, that additionally meets the standards in Sec. 418.202 (a) and (e) regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management. Inpatient care may also be furnished as a means of providing respite for the individual's family or other persons caring for the individual at home.

Respite care must be furnished as specified in Sec. '§ 418.108(b). Payment for inpatient care will be made at the rate appropriate to the level of care as specified in Sec. 418.302.

(f) Medical appliances and supplies, including drugs and biologicals. Only drugs as defined in section 1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

Appliances may include covered durable medical equipment as described in Sec.

<p>410.38 of this chapter as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness.</p> <p>Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care.</p> <p>(g) Home health aide services furnished by qualified aides as designated in Sec. § 418.76 and homemaker services. Home health aides may provide personal care services as defined in Sec. 409.45(b) of this chapter. Aides may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing bed linens or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in maintenance of a safe and healthy environment and services to enable the individual to carry out the treatment plan.</p> <p>(h) Physical therapy, occupational therapy and speech-language pathology services in addition to the services described in Sec. 409.33 (b) and (c) of this chapter provided for purposes of symptom control or to enable the patient to maintain activities of daily living and basic functional skills.</p> <p>(i) Effective April 1, 1998, any other service that is specified in the patient's plan of care as reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions and for which payment may otherwise be made under Medicare.</p>	
<p>§ 418.204 Special coverage requirements.</p> <p>(a) Periods of crisis. Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide services or both may</p>	

<p>be covered on a 24-hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.</p> <p>(b) Respite care. (1) Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual.(2) Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time.</p> <p>(c) Bereavement counseling. Bereavement counseling is a required hospice service but it is not reimbursable.</p>	
<p>Subpart G--Payment for Hospice Care</p>	

Iowa Dept of Public Health Regs re Home Health Aides: 641 I.A.C. 80.10(3)

Authorized agency.

- a. The authorized agency shall establish policies for supervision of direct care workers.
- b. The authorized agency shall ensure that each direct care worker has completed adequate training and demonstrated competency for each task assigned. The required preservice education for direct care workers is outlined in the following chart:

c.

Level of Direct Care Worker	Direct Care Worker I (equivalent to chore)	Direct Care Worker II (equivalent to home helper)	Direct Care Worker III (equivalent to homemaker)	Direct Care Worker IV (equivalent to personal care)	Direct Care Worker V (equivalent to protective worker)
Scope of Services	Provides services to a consumer necessary to enable the consumer to live independently and that encompass heavier cleaning tasks, including outside maintenance and chores. For chore services, there is no physical contact between the consumer and the direct care worker	Under the supervision of a professional, provides services to protect the environment for a self-directing consumer to preserve a safe and sanitary home	Under the supervision of a professional, provides services primarily in the homes of consumers who, due to the absence, incapacity or limitations of the usual homemaker or caregiver, are experiencing stress or crisis, to promote consumer health and a safe, stable, sanitary home environment	Under the direction of nursing or medical staff, provides health-related services such as observation of self-administration of oral medications; checking the consumer's pulse rate, temperature, and respiration rate; helping with simple prescribed exercises; keeping the consumer's rooms neat; changing nonsterile dressings; providing skin care and back rubs; assisting with braces and artificial limbs; or assisting the consumer in using medical	Provides services intended to stabilize a child's or adult's residential environment and relationships with relatives, caretakers, and other consumers and household members in order to alleviate a situation involving abuse or neglect or to otherwise protect the child or adult from a threat of abuse or neglect; also provides services intended to prevent situations which could lead to abuse or neglect of a child or adult

Level of Direct Care Worker	Direct Care Worker I (equivalent to chore)	Direct Care Worker II (equivalent to home helper)	Direct Care Worker III (equivalent to homemaker)	Direct Care Worker IV (equivalent to personal care)	Direct Care Worker V (equivalent to protective worker)
				equipment	when a definite potential for abuse or neglect exists
Services or tasks assigned include, but are not limited to:	Heavy household cleaning, garbage removal, snow shoveling, changing light bulbs, putting screens on windows, covering and uncovering air conditioners, lawn care and mowing	Essential shopping and housekeeping	Money management, household management, consumer education, transportation, meal preparation, family preservation, family management, child care, assistance with personal care, respite, essential shopping, and housekeeping	Personal care and rehabilitative therapies	Family preservation, family management, money management, child care, and transportation
Preservice Education	Direct care worker possesses skills for tasks assigned	4 hours on role of the home care aide; 2 hours on communication; 2 hours on understanding basic human needs; 2 hours on maintaining a healthy environment; 2 hours on infection control in the home; and 1 hour on emergency procedures	60-hour home care aide training: A Model Curriculum and Teaching Guide for the Instruction of the Homemaker-Home Health aide OR 75-hour certified nurse aide course and Direct Care Worker II preservice education OR Home care	60-hour home care aide training: A Model Curriculum and Teaching Guide for the Instruction of the Homemaker-Home Health aide OR 75-hour certified nurse aide course and Direct Care Worker II preservice education OR Home care	Training in a department-approved curriculum

Level of Direct Care Worker	Direct Care Worker I (equivalent to chore)	Direct Care Worker II (equivalent to home helper)	Direct Care Worker III (equivalent to homemaker)	Direct Care Worker IV (equivalent to personal care)	Direct Care Worker V (equivalent to protective worker)
			aide training and prior approval by the department	aide training and prior approval by the department	
Workforce Development (per calendar year)	None	3 hours prorated to employment	12 hours prorated to employment	12 hours prorated to employment	12 hours prorated to employment
Competency	Documented skills for assigned tasks	Documented skills for assigned tasks	Documented skills for assigned tasks	Documented skills for assigned tasks	Documented skills for assigned tasks