Sec. 19-13-D72. Patient care policies

(a) **General Program Policies.** An agency shall have written policies governing referrals received, admission of patients to agency services, delivery of such services and discharge of patients. Such policies shall cover all services provided by the agency, directly or under contract. A copy shall be readily available to patients and staff and shall include but not be limited to:

(1) Conditions of Admission:

(A) An agency shall accept a plan of treatment from a chiropractor for services within the scope of chiropractic practice as defined in Connecticut General Statutes Sec. 20-28, and an agency shall accept a plan of treatment from a podiatrist for service within the scope of podiatry practice as defined in Connecticut General Statutes Sec. 20-50. The agency shall have policies governing delivery of these services. Said policies shall conform to all applicable sections of these regulations;

(B) A home assessment by the primary care nurse or, when delegated by the supervisor of clinical services, by other professional staff, to determine that the patient can be cared for safely in the home;

(C) The scope of agency, patient and, when appropriate, family and/or other participation in the home health services to be provided;

(D) Circumstances which render a patient ineligible for agency services, including but not limited to level of care needs which make care at home unsafe, kinds of treatments agency will not accept, payment policy and limitations on condition of admission, if any;

(E) Plan for referral of patients not accepted for care;

(F) Any delay in the start of service shall require prior notification to the patient.

Such notification shall include the anticipated start of service date and the agency's plan while the patient is on the waiting list;

(G) The policies define agency responsibility, plan and procedures to be followed to assure patient safety in the event patient services are interrupted for any reason.

(2) Delivery of Services:

(A) Review of Patient Care Plans;

(B) Case management and monitoring at regular intervals based upon the patient's condition, but at least every sixty (60) days. The patient, family, physician or dentist and all agency staff serving the patient shall participate in case management;

(C) Summary reports to patient's physician or dentist of skilled services provided to patient, which shall be forwarded within ten (10) days of admission and at least every sixty (60) days thereafter;

(D) Coordination of agency services with all other facilities or agencies actively involved in patient's care;

(E) Referral to appropriate agencies or sources of service for patients who have need of care not provided by the agency;

(F) Emergency plan and procedures to be followed to assure patient safety in the event agency services are disrupted due to civil or natural disturbances, e.g., hurricanes, snowstorms, etc.

(3) Discharge from Service:

(A) Agency policies shall define categories for discharge of patients. These categories

shall include but not be limited to:

(i) Routine discharge - termination of service(s) when goals of care have been met and patient no longer requires home health care services;

(ii) Emergency discharge - termination of service(s) due to the presence of safety issues which place the patient and/or agency staff in immediate jeopardy and prevent the agency from delivering home health care services;

(iii) Premature discharge - termination of service(s) when goals of care have not been met and patient continues to require home health care services;

(iv) Financial discharge - termination of service(s) when the patient's insurance benefits and/or financial resources have been exhausted.

(B) In the case of a routine discharge the agency shall provide:

(i) pre-discharge planning by the primary care nurse, attending physician, or dentist and other agency staff involved in patient's care, which shall be documented in patient's clinical record;

(ii) A procedure through which the patient's physician or dentist is notified each time one or more services are terminated, and when the patient is discharged.

(C) In the case of an emergency discharge the agency shall immediately take all measures deemed appropriate to the situation to ensure patient safety. In addition, the agency shall immediately notify the patient, the patient's physician, and any other persons or agencies involved in the provision of home health care services. Written notification of action taken, including date and reason for emergency discharge, shall be forwarded to the patient and/or family, patient's physician, and any other agencies involved in the provision of home health care services within five (5) calendar days.

(D) In the case of a premature discharge the agency shall document that prior to the decision to discharge a case review was conducted which included patient care staff, supervisory and administrative staff, patient's physician, patient and/or patient representative, and representation from any other agencies involved in the plan of care.

(i) Decision to continue service:

If the decision of the case review is to continue to provide service, a written agreement shall be developed between the agency and the patient or his/her representative to identify the responsibilities of both in the continued delivery of care for the patient. This agreement shall be signed by the agency administrator and the patient or his representative. A copy shall be placed in the patient's clinical record with copies sent to the patient and his or her physician.

(ii) Decision to discharge from service:

If the case review results in an administrative decision to discharge the patient from agency services, the administrator shall notify the patient and/or family and the patient's physician that services shall be discontinued in ten (10) days and the patient shall be discharged from the agency. Services shall continue in accordance with the patient's plan of care to ensure patient safety until the effective day of discharge. The agency shall inform the patient of other resources available to provide health care services.

(E) In the case of a financial discharge the agency shall conduct a:

(i) Pre-termination Review: Whenever one or more home health services are to be terminated because of exhaustion of insurance benefits or financial resources, at least ten

(10) days prior to such termination there shall be a review of need for continuing home health care by the patient, his family, the supervisor of clinical services, the patient's physician or dentist, primary care nurse and other staff involved in the patient's care. This determination and, when indicated, the plan developed for continuing care shall be documented in the patient's clinical record.

(ii) Post-termination Review: The clinical records of each patient discharged because of exhaustion of insurance benefits or financial resources shall be reviewed by the professional advisory committee or the clinical record review committee at the next regularly scheduled meeting following the discharge. The committee reviewing the record shall ensure that adequate post-discharge plans have been made for any patient with continuing home health care needs.

(b) **Patient Care Standards:**

(1) Infusion therapy may be provided to patients of a home health care agency provided services exclude the administration of blood and blood products and a program to monitor the effectiveness and safety of the infusion therapy is developed and implemented.

(A) Definitions

(i) "Infusion therapy" means intravenous, subcutaneous, intraperitoneal, epidural or intrathecal administration of medications, or solutions excluding blood or blood products.

(ii) "Care partner" means a person who demonstrates the ability and willingness to learn maintenance of infusion therapy and who, if not residing with the patient, is readily available to the patient on a twenty four (24) hour basis.

(B) Licensed registered nursing staff who are trained to perform infusion therapy shall be responsible for:

(i) Insertion or removal of a peripherally inserted central catheter (picc), upon the written order of a physician, provided the registered nurse has had appropriate training and experience in such procedures; and

(ii) Delivering of infusion therapy via existing epidural, intraperitoneal and intrathecal lines, monitoring, care of access site and recording of pertinent events and observations in the patient's clinical record.

(C) Licensed nursing staff trained in infusion therapy shall be responsible for:

(i) Performing a venipuncture for the delivery of intravenous fluids via a needle or intracath;

(ii) Withdrawal of blood from applicable infusion mechanisms for laboratory analysis; and

(iii) Delivering intravenous therapy via existing lines, monitoring, care of access site and recording pertinent events and observations in the patient's clinical record.

(D) Only a physician shall insert and remove central venous lines, epidural, intraperitoneal and intrathecal lines except as permitted in section (b) (1) (B) (i).

(E) A program to monitor the effectiveness and safety of the agency's infusion therapy services shall be developed, implemented and monitored.

(F) Infusion therapy services shall be provided in accordance with agency protocol, and practitioners orders and current standards of professional practice.

(G) Policies and procedures for infusion therapy shall be developed and implemented to address:

(i) Timely initiation and administration of infusion therapy;

(ii) Scope of infusion therapy services, therapeutic agents, staff credentials and training necessary to perform infusion therapy;

(iii) Training of patient or care partner to perform infusion therapy;

(iv) Infusion therapy orders, which shall include, type of access, drug, dosage, rate and duration of therapy, frequency of administration, type and amount of solution;

(v) Documentation of infusion therapy services in the patient's clinical record; and

(vi) Adverse reactions and side effects of infusion therapy.

(H) Current reference materials shall be available for staff relevant to infusion therapy services rendered by the agency.

(2) Hospice services delivered in a patient's home may be provided only by a home health care agency licensed pursuant to Section 19a-491 of the Connecticut General Statutes, with the approval of the Commissioner of Public Health. An agency shall make application for the provision of hospice services on forms provided by the Department of Public Health. Prior to the provision of hospice services, the Commissioner shall approve an agency to provide these services, if the agency meets all of the requirements of this subdivision, and shall note this approval on the license of the home health care agency.

(A) Definitions

As used in Section 19-13-D72(b)(2) of the Regulations of Connecticut State Agencies:

(i) "Attending Physician" means a doctor of medicine or osteopathy, licensed pursuant to Chapter 370 or 371 of the Connecticut General Statutes, or licensed in a state which borders Connecticut, who is identified by the patient at the time of selection of hospice care as having the most significant role in the determination and delivery of the patient's medical care;

(ii) "Bereavement Counselor" means a person qualified through education and experience to counsel patients and family members on issues relating to loss and grief. The hospice program shall define the qualifications necessary to address the unique needs of each population served;

(iii) "Primary Caregiver" means a person who provides care for the patient and who, if not residing with the patient, is readily available to assure the patient's safety;

(iv) "Case Management" means the coordination and supervision of all hospice care and services, to include periodic review and revision of the patient's plan of care and services, based on ongoing assessments of the patient's needs;

(v) "Coordination of Inpatient Care Agreement" means an agreement between the agency and a contractor, which may include an inpatient setting or other health care professionals, for the provision of services during an inpatient admission by the contractor and which includes, but is not limited to, mechanisms for collaboration and coordination of care and sharing of information to meet the ongoing needs of the patient family;

(vi) "Counseling Services" means medical social work, bereavement, spiritual, dietary and other counseling services as required in the plan of care;

(vii) "Family" means group of two or more individuals related by blood, legal status, or affection who consider themselves a family;

(viii) "Home" means the place where a hospice patient resides and may include but is not limited to a private home, nursing home, or specialized residence which provides

supportive services;

(ix) "Hospice Employee" means a paid or unpaid staff member of the hospice program;

(x) "Hospice Interdisciplinary Team" means a specifically trained group of professionals licensed pursuant to Title 20 of the Connecticut General Statutes, and volunteers, including but not limited to a physician, a registered nurse, a consulting pharmacist and one or more of the following: a social worker, a spiritual, bereavement or other counselor, the volunteer coordinator, a volunteer with a role in the patient's plan of care, who work together to meet the physiological, psychological, social, and spiritual needs of hospice patients and their families;

(xi) "Hospice Program" means a program of the home health care agency that is the primary agency engaged in coordinating the provision of care and services to patients who are terminally ill from the time of admission to the hospice program throughout the course of the illness until death or discharge;

(xii) "Inpatient setting" means an institution; licensed in the state in which it is located, which includes a short-term hospital, general, a chronic and convalescent nursing home, or a short-term hospital, special, hospice. A rest home with nursing supervision may also be included for the provision of respite care only;

(xiii) "Medical Director" means a doctor of medicine or osteopathy, licensed pursuant to Chapter 370 or 371 of the Connecticut General Statutes, or licensed in a state which borders Connecticut, who assumes overall responsibility for the medical component of the hospice's patient care program and who is an employee of the hospice program;

(xiv) "Palliative Care" means treatment which enhances comfort and improves the quality of a patient's life;

(xv) "Patient Family" means the hospice patient, his or her family members or primary caregivers; the patient family is considered to be a unit and the recipients of hospice care;

(xvi) "Pharmaceutical Services" means pharmacy services provided directly or by contract to patients, primarily for the relief of pain and other symptoms related to the terminal illness, and consultation to the hospice interdisciplinary team;

(xvii) "Plan of Care" means a written, individualized plan of care developed for a hospice patient, in accordance with the wishes of the patient, with the participation of the patient family, attending physician, medical director and members of the hospice interdisciplinary team as appropriate;

(xviii) "Qualified Dietitian" means a dietitian who is registered by the Commission on Dietetic Registration or certified as a dietitian-nutritionist by the Department pursuant to Chapter 384b of the Connecticut General Statutes;

(xix) "Spiritual" means those aspects of a human being associated with the emotions and feelings, which are unique to each individual, as distinguished from the physical body;

(xx) "Spiritual Counselor" means a person who is qualified through education and experience to provide spiritual counseling and support. The hospice program shall define the qualifications necessary to address the unique needs of each population served;

(xxi) "Terminally Ill" means having a diagnosis of advanced irreversible disease, as attested to by a licensed physician;

(xxii) "Volunteer" means an unpaid associate of the hospice program who has successfully completed a training program in preparation for providing assistance to hospice

patient families and assisting in the administrative activities of the hospice;

(xxiii) "Volunteer Coordinator" means an employee of the hospice program who has demonstrated skills in organizing, communicating with and managing people.

(B) An agency shall develop and implement written policies and procedures for all hospice services provided which include:

(i) A description of the objectives and scope of each service to be provided, both directly and by contract which assures the continuity of care from the time of admission to the hospice program throughout the course of the patient's illness until death or discharge. Such services shall include coordination of inpatient care agreements for care as needed in inpatient settings;

(ii) Admission criteria for accepting a patient family for hospice services which includes, but is not limited to, a statement of a physician's or the medical director's clinical judgment regarding the normal course of the individual's illness and a requirement that patients will not be discharged from the hospice program solely as a result of admission to an inpatient setting with which the hospice program has a coordination of inpatient care agreement;

(iii) Procedures for the provision of care and services to the patient family including advising the patient or legal representative of the nature of the palliative care offered. Palliative care includes pain control, symptom management, quality of life enhancement and spiritual and emotional comfort for patients and their caregivers; the patient's needs are continuously assessed and all treatment options are explored and evaluated in the context of the patient's values and symptoms;

(iv) Qualifications for all providers of care and services in accordance with State law and regulations;

(v) Availability of services;

(vi) Orientation and training for all providers of care and services to the hospice philosophy of patient care. The hospice program shall be responsible for educating all unlicensed personnel assigned to provide services to hospice patient families regarding hospice goals, philosophy and approaches to care;

(vii) For hospice employees, six hours of the annual in-service education requirements in accordance with Section 19-13-D71(a)(2) of these regulations shall address topics related to hospice care. The agency shall ensure, as part of its coordination of inpatient care agreement with an inpatient setting, that all direct service staff receive in-service education including two hours specific to hospice care. The in-service education shall include current information regarding drugs and treatments, specific service procedures and techniques, pain and symptom management, psychosocial and spiritual aspects of care, interdisciplinary team approach to care, bereavement care, acceptable professional standards, and criteria and classification of clients served;

(viii) The procedure for the disposal of controlled drugs maintained in the patient's home by the family or primary caregiver, when those drugs are no longer needed by the patient, in accordance with accepted safety standards.

(C) A hospice program shall have a written quality improvement plan and program which guides the hospice program toward improving organizational performance and achieving the desired outcomes for patient families.

(D) In addition to the membership requirements set forth in Section 19-13-D68(c) of

these regulations, a hospice program shall appoint a pharmacist, a volunteer and members of other professional disciplines as appropriate to the agency's Professional Advisory Committee.

(E) The hospice interdisciplinary team shall be composed of individuals who have clinical experience and education appropriate to the needs of the terminally ill and their families. The team shall include:

(i) The medical director, or physician designee;

(ii) A registered nurse, licensed pursuant to Chapter 378 of the Connecticut General Statutes;

(iii) A consulting pharmacist, licensed pursuant to Chapter 400j of the Connecticut General Statutes;

(iv) and one or more of the following, based on the needs of the patient:

I. A social worker, licensed pursuant to Chapter 383b of the Connecticut General Statutes;

II. A bereavement counselor;

III. A spiritual counselor;

IV. A volunteer coordinator;

V. A trained volunteer who is assigned a role in the patient's plan of care;

VI. A physical therapist, occupational therapist or speech-language pathologist.

(F) Interdisciplinary team members shall participate, to the extent of the scope of services provided to a patient family, in:

(i) The admission process and initial assessment for services;

(ii) The development of initial patient family plan of care, within 48 hours of admission;

(iii) Ongoing case management.

(G) The plan of care shall be individualized and interdisciplinary, addressing the patient family. The plan for each service provided to the patient family shall include, but not be limited to, assessment of patient family needs as they relate to hospice services, goals of hospice management, plans for palliative intervention, bereavement care and identification of advance directives.

(i) The hospice program shall assure coordination and continuity of the plan of care, 24 hours per day, seven days per week from the time of admission to the hospice program throughout the course of the patient's illness until death or discharge. A copy of the plan of care shall be furnished to providers in inpatient or other settings where the patient may be temporarily placed and shall include the inpatient services to be furnished;

(ii) The hospice supervisor of clinical services shall be responsible for coordination and management of all services, including those provided directly and by contract, to hospice patient families;

(iii) The plan of care for all hospice services shall be reviewed and revised by members of the interdisciplinary team as often as the patient's condition indicates, but no less frequently than every 14 days.

(H) Assessments and plans of care shall be documented and retained in the clinical record. The clinical record shall also include progress notes from each involved discipline.

(I) Case management shall be implemented based on the patient's condition, but occur no less frequently than every 14 days, and shall include the participation of the patient, family, physician and all members of the interdisciplinary team who are serving the patient

family.

(J) There shall be a full-time hospice program director, appointed by the governing authority of the home health care agency, who shall have responsibility to plan, staff, direct and implement the hospice program. The hospice program director shall either:

(i) Be qualified in accordance with Section 19-13-D67(a) of the Regulations of Connecticut State Agencies, but with hospice or home health care supervisory or administrative experience which included care of the sick, in lieu of experience in a health care facility or program; or

(ii) Possess a master's degree in social work and at least one year of supervisory or administrative experience in a hospice or home health care agency.

(K) An agency offering a hospice program shall employ a medical director.

(i) A hospice program medical director shall have a minimum of five years of clinical experience in the practice of medicine or osteopathy.

(ii) The medical director shall be knowledgeable about the psychosocial, spiritual, and medical aspects of hospice care;

(iii) The medical director's responsibilities shall include, but not be limited to:

I. Development and periodic review of the medical policies of the hospice program;

II. Consultation with attending physicians regarding pain and symptom control and medical management as appropriate;

III. Participation in the development of the plan of care for each patient admitted to the hospice;

IV. Serving as a resource for the hospice interdisciplinary team;

V. Acting as a liaison to physicians in the community;

VI. Assuring continuity and coordination of all medical services.

(L) Medical care and direction shall be provided by the patient's attending physician or the hospice medical director. Orders to administer medications shall be written and signed by the patient's attending physician or the hospice medical director.

(M) Nursing services shall be provided by qualified nurses licensed pursuant to Chapter 378 of the Connecticut General Statutes, employed by the hospice program and under the supervision of a primary care nurse.

(i) In addition to the requirements of Section 19-13-D68(e) of these regulations, an agency providing a hospice program shall employ one qualified full-time registered nurse supervisor of clinical services for each ten or fewer, full-time or full-time equivalent professional direct service staff assigned to the hospice program, who shall manage and supervise the day to day activities of the hospice program, including coordination of the interdisciplinary team;

(ii) The supervisor of clinical services assigned to the hospice program may also serve as the hospice program director in programs with six or fewer full-time or full-time equivalent professional direct-services staff.

(iii) A registered nurse, serving as the primary care nurse, shall be responsible for the following:

I. Development and implementation of an individualized, interdisciplinary patient family plan of care;

II. Admission of patients for service and development of the initial patient family plan of care within 48 hours of admission with input from at least one other member of the hospice

interdisciplinary team;

III. Coordination of services with the patient family, hospice interdisciplinary team members and all others involved in the plan of care and delivery of patient care services.

(N) Social work services shall be provided by qualified social workers, licensed pursuant to Chapter 383b of the Connecticut General Statutes, employed by the hospice program. The social worker's functions shall include, but not be limited to:

(i) Comprehensive evaluation of the psychosocial status of the patient family as it relates to the patient's illness and environment;

(ii) Counseling of the patient family and primary caregivers;

(iii) Participation in development of the plan of care;

(iv) Participation in ongoing case management with the hospice interdisciplinary team.

(O) Counseling shall include bereavement, spiritual, dietary, and any other counseling services that may be needed by the patient family while enrolled in a hospice program.

(i) Counseling shall be provided only by qualified personnel employed by the hospice;

(ii) Bereavement services shall include:

I. Ongoing assessment of the family and primary caregiver's needs, including the presence of any risk factors associated with the patient's impending death or death and the ability of the family or primary caregiver to cope with the loss;

II. A plan of care for bereavement services which identifies the individualized services to be provided;

III. The availability of pre-death grief counseling for the patient family and primary caregiver;

IV. Ongoing, regular, planned contact with the family and primary caregiver, offered for at least one year after the death of the patient, based on the plan of care;

(iii) A spiritual counselor shall provide counseling, in accordance with the wishes of the patient, based on initial and ongoing assessments of the spiritual needs of the patient family that, at a minimum, include the nature and scope of spiritual concerns or needs. Services may include:

I. Spiritual counseling consistent with patient family beliefs;

II. Communication with and support of involvement by local clergy or spiritual counselor;

III. Consultation and education for the patient family and interdisciplinary team members.

(iv) A qualified dietitian shall provide counseling based on initial and ongoing assessments of the current nutritional status of the patient, pre-existing medical conditions, and special dietary needs. Services may include:

I. Counseling of the patient family and primary caregiver with regard to the patient's diet;

II. Coordination of the plan of care with other providers of nutritional services or counseling.

(P) The hospice program shall have volunteer services available to the hospice patient family. Management of the ongoing active volunteer program including orientation and education, shall be designated in writing to a full-time hospice employee, who may have other responsibilities in addition to those of volunteer coordinator.

(i) Volunteers may be utilized in administrative or direct patient family care roles;

(ii) The hospice program shall provide orientation, ongoing training and supervision of its volunteers consistent with the duties and functions to be performed;

(iii) Volunteers who are qualified to provide professional or homemaker-home health aide services shall meet all standards, licensing or credentialing requirements associated with their discipline.

(Q) The hospice program, which shall serve as the patient's primary agency, may provide services by contract with an agency or individual and shall have legally binding written agreements for the provision of such contracted services in accordance with the requirements of Section 19-13-D70 of the Regulations of Connecticut State Agencies. If a hospice program enters into a coordination of inpatient care agreement with an inpatient setting, the written agreement shall include, but not be limited to, provisions for accommodations for family members to remain with the patient overnight, space for private patient and family visiting, homelike decor, and privacy for the family after a patient's death.

(R) Pharmaceutical services, including consultation with hospice program staff regarding patient needs, shall be made available by the hospice program 24 hours a day, 7 days a week.

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