

# CHAPTER 10 – ARTICLE 6

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**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** *empty***IP Address:** 24.251.153.14**Response Started:** Sunday, May 5, 2013 2:22:07 PM**Response Modified:** Sunday, May 5, 2013 2:29:04 PM**1. What parts of the draft rules do you believe are effective?**No Response

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**2. How can the draft rules be improved?**

R9-10-615 Food Services for a Hospice Inpatient Facility 3. Meals for each day are planned using: a. The applicable meal planning guides in [http://www.fns.usda.gov/cnd/Care/ProgramBasics/Meals/Meal\\_Pattern.htm](http://www.fns.usda.gov/cnd/Care/ProgramBasics/Meals/Meal_Pattern.htm); and ADD - A registered dietitian: a. Reviews a food menu before the food menu is used to ensure that a patient's nutritional needs are being met, b. Documents the review of a food menu, This used to be on the regulations but have been removed in this draft The Menu Planning guide is not as easy to follow as it looks Having an RD will ensure that the meal planning pattern referenced above is followed. It is then the patient's right to follow it or not Having a registered dietitian review that menus will cost the facility as little as \$ 200 a year A small price to pay NOTE that other agencies have the RD review menus

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**3. Has anything been left out that should be in the rules?**Add back in, the Registered Dietitian reviewing menus, as part of the regulations

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**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 76.178.109.7**Response Started:** Saturday, May 4, 2013 10:43:03 PM**Response Modified:** Saturday, May 4, 2013 11:11:58 PM**1. What parts of the draft rules do you believe are effective?**

The draft rules that mirror Medicare CoPs are reasonable

**2. How can the draft rules be improved?**

Rather than create different rules for state regulations and federal Medicare regulations, and give additional regulatory burdens to health care institutions that are already heavily overburdened with excessive regulatory and documentation requirements, the state rules should mirror Medicare CoPs. R9-10-805 Patient Admissions A2. Should mirror Medicare CoPs - "terminal illness with prognosis of 6 months or less " Many people die of multiple chronic conditions, not just one specific disease. The current language does not reflect current understanding of the actual illnesses that cause people to die. C "time of admission is not clear. Should be same as Medicare CoPs - within 5 days of hospice admission. A3a Hospice service is palliative, not curative - this statement does not reflect the emerging understanding of chronic disease management. Chronic diseases are not cured, but can be managed, and eventually reach a terminal state. R9-10-807 Plan of Care - should be same regulations as Medicare CoPs. R9-10-808 Hospice Service: A3 Menu planning for home hospice patients is not appropriate. When a person is terminally ill, his/her condition may change quickly, and therefore appropriate food intake will also change. Hospice professionals teach families how to manage patient's nutritional needs in the home environment. Food preferences are very personal. Patients should be able to eat what they like, and what they are able to eat on a given day. Designing the kind and amount of food that should be eaten by a terminally ill patient at home goes completely against hospice philosophy and is totally inappropriate to regulate at level of government. Furthermore, some patients receive food boxes from food bank; it is impossible to know ahead of time what will be in the food box. Again, this proposed regulation is totally inappropriate and impossible to implement in the home hospice setting. This regulation should be deleted. C6: Same issue as A3 - it is totally inappropriate, in a home hospice setting, to have a registered dietitian plan menus for a terminally ill patient. This regulation should be deleted. C7: For patients in the home hospice setting, assistance with meals is provided by families. It is totally not feasible, and completely inappropriate and very intrusive to families to require hospice providers to be present in the home to feed patients all meals. This regulation should be deleted. C9: again, this regulation should be deleted. It is totally impossible to regulate how families provide water to the terminally ill patient in their home. C10: this regulation is not clear. Does it mean that if a patient's condition changes several times in a day, that multiple contacts need to be made? Many physicians do not want this kind of contact, and would become angry with the hospice, and consider that the hospice is "bothering" them or harassing them. A hospice, in collaboration with each physician, should be able to decide how such notifications are made.

**3. Has anything been left out that should be in the rules?**

No Response



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**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 173 197 216.68**Response Started:** Thursday, May 2, 2013 11:24:42 AM**Response Modified:** Thursday, May 2, 2013 12:41:03 PM**1. What parts of the draft rules do you believe are effective?**

Thank you for giving us the opportunity to comment

**2. How can the draft rules be improved?**

The rules would be more effective and beneficial to everyone if they mirrored Medicare unless the State has an objection to a specific reg that they feel that by complying with the reg it would harm the patient Page 13: Define "at the time of admission". We do admissions, not only during regular business hours but also evenings and weekends If a Social Worker is expected to be there at the same time as the nurse, when the patient elects hospice, then there will be times when an admission will have to be delayed which could cause undue burden on the patient and family Could it be within 24 or 48 hours? Medicare allows for 5 days maximum but sooner is better and a social worker is contacted to visit if the nurse identifies an immediate need We have a social worker on call at all times but they are not expected to routinely work each shift. Page 17: Define menu planning for home patients? And it must be a registered dietitian? Are you referring to the type of diet such as low salt, high protein, etc or are you implying a menu for each meal? Some of our patients receive food boxes from the food bank. You never know what may be in the boxes and it may be moldy when it arrives Also, what about patients who live alone and do not cook Please specify what is Menu Planning in the home I can understand in a facility but not specific meals in a home Page 19: A registered dietitian plans menus; the hospice assists with feedings Does this imply that the hospice will feed each patient in the home who cannot feed themselves? We ensure that patients have food and water available to them, especially those who live alone Even if that means buying them fast food or microwavable food and staff paying out of their own pocket The way this is written it implies that we must prepare and feed the patient as well. Some of these home patients should be in a SNF or assisted living but are competent to make their own decisions and refuse Are we then to be their caregiver? Page 13: Patient Admissions: A 2 Specific Disease. Since patients usually die from multiple diseases rather than one specific disease, our physician would like clarification on this. We are a very proactive agency and institute new rules and regs before they go into effect so that when they are in effect it is seamless. However, you sent an email on April 17th with an attachment of the Draft Rules This was the first we were aware of them Had we been emailed prior and missed it or was this the first email from the AZDHS? Page 18: Medical Social Services, provided by an individual licensed We have a LMSW and BSWs who are not licensed Hopefully, we can accomplish their licensing prior to July 1st A notification prior to April 17th from you would have helped to ensure that we accomplished this The current regs do not require social work licensing and neither does Medicare

**3. Has anything been left out that should be in the rules?**

Page 10: Define who is responsible to review the policies Medicare requires that the administrative and personnel policies are reviewed annually by the governing body. Medicare also states that the clinical policies are reviewed by the Interdisciplinary Group. Since we must review annually why would you define every 24 months? Were any of the individuals who wrote and revised the AZ State regulations for Hospices aware of the 2008 revised Medicare Hospice Conditions of Participation?



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**2. How can the draft rules be improved?**No Response

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**3. Has anything been left out that should be in the rules?**Yes all hospice workers provide care in the home and should be required by the state to have a DPS fingerprint clearance card All hospice care is not provided in a inpatient setting

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