SB

96

FISCAL NOTE

STATE OF ALASKA
1997 LEGISLATIVE SESSION

BILL NO. CSSB96(HESS)

Revision Date:
Title: Regulating Hospice Care
Sponsor: Senate Rules by Request
Requestor: Senate HESS

Dept. Affected: Health and Social Services
BRU: Medical Assistance Admin
Component: Certification & Licensing
COMPONENT SERIAL NO. 245
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY98	FY99	FY00	FY01	FY02	FY03
PERSONAL SERVICES						
TRAVEL	7.5	8.9	10.4	12.0	13.7	15.4
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	7.5	8.9	10.4	12.0	13.7	15.4
CAPITAL EXPENDITURES						
CHANGES IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

FUND SOURCE	FY98	FY99	FY00	FY01	FY02	FY03
1002 Federal Receipts						
1003 GF Match						
1004 GF	7.5	8.9	10.4	12.0	13.7	15.4
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	7.5	8.9	10.4	12.0	13.7	15.4

POSITIONS:

POSITIONS	FY98	FY99	FY00	FY01	FY02	FY03
FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY97) cost: $0.0

ANALYSIS: (Attach a separate page if necessary)

CSBill 96 would require licensure of 6 new hospice facilities outside of anchorage. These travel costs were arrived at by using FY97 calculations for travel for one surveyor to travel for a 4 day survey to each of these agencies. Additionally, it is expected at least one new initial survey would be expected each year at a cost of about $1,000.00 each. Also, anticipating the increased cost of travel, lodging and care rental we added 5% per year.

Prepared by: Shelbert Larsen SL
Division: Medical Assistance
Phone: (907) 561-8081
Date: 04/09/97

JMY 4/9/97

Approved by Commissioner: Karen Perdue, Commissioner [signature]
Agency: Department of Health & Social Services
Date: 4-9-97

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Prepared by: Shelbert Larsen
Division: Medical Assistance
Phone: (907)561-8081
Date: 02/24/97

Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 3/5/97

2/24/97

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SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/19/97

FURTHER: Finance

Date of 5-Day Notice: 2/20/97
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 4/10/97

HESS Committee considered SENATE BILL NO. 96

"An Act regulating hospice care."

and recommends:

[ ] be replaced with ______ CS SB 96 (HES)

[ ] adopt previous ______ CS ______ (______)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by ______ Committee

[ ] further referral to the ______ Committee

Senate Bill:
[ ] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR* ______

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	NR	DNP	AM
[signature]	X	[signature]			X
		[signature]			✓
		[signature]	✓		
CHAIR: [signature]	✓	CHAIR:			

NEW FISCAL NOTE(S):

	Department	Date	Zero	Fiscal
SB	Health + Social Services	3/5/97		7.5
CS	Health + Social Services	4/9/97		7.5

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal

[ ] APPROPRIATION -- no fiscal note

*include fiscal notes accompanying Governor's bill

0-LS0602\K
Lauterbach
3/25/97
Sen. Kelly

Version that passed (S) HESS 4/9/97

CS FOR SENATE BILL NO. 96( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST

A BILL

FOR AN ACT ENTITLED

1 "An Act regulating hospice care."

2 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

3 * *Section 1.* AS 18 is amended by adding a new chapter to read:

4 **Chapter 18. Hospice Care Programs.**

5 **Article 1. Licensing of Hospice Programs.**

6 **Sec. 18.18.005. Policy declaration.** It is the policy of the state that regulation
7 of hospice programs should ensure an appropriate standard of care for hospice clients
8 without unduly burdening the programs with requirements that consume staff time and
9 financial resources that are essential for the delivery of services to hospice clients. In
10 furtherance of this policy, this chapter establishes two sets of standards for hospice
11 programs that recognize the more limited staff time and financial resources available
12 to voluntary hospice programs while requiring all programs to comply with basic
13 minimum program standards.

14 **Sec. 18.18.010. License required.** A person, including a partnership,
15 association, or corporation, may not represent itself as a hospice program or operate

1 a hospice program unless the person, partnership, association, or corporation has
2 obtained a license from the department.
3 **Sec. 18.18.020. Issuance and renewal of license.** (a) Upon receiving an
4 application and fee, if any, for a license under this chapter, the department shall issue
5 a license if the applicant meets the applicable requirements of this chapter.
6 (b) If an applicant under (a) of this section does not meet the applicable
7 requirements but makes continued efforts to comply with them and any noncompliance
8 does not directly affect the safety of clients, the department may issue a temporary or
9 provisional license that is valid for a reasonable period of time, as determined by the
10 department.
11 (c) A license under this chapter shall be issued in the name of the person,
12 agency, or other entity specified in the application and is not transferable or assignable
13 without the written approval of the department.
14 (d) The department shall, by regulation, establish the application fee, license
15 fee, length of time that a license is valid, and the standards for license renewal. A
16 license is not renewable during the time it has been suspended or revoked under this
17 chapter.
18 **Sec. 18.18.030. Denial, suspension, or revocation of license.** (a) The
19 department may deny a license, reduce a license to a provisional license, or revoke a
20 license if the department finds that the applicant or licensee, as appropriate, or the
21 program director or medical director of the applicant or licensee, as applicable, has
22 (1) endangered the health, safety, or welfare of a client;
23 (2) a history of deficiencies in quality of care;
24 (3) had a license to operate a hospice program suspended or revoked
25 in another licensing jurisdiction for a reason other than failure to pay a licensing fee;
26 (4) been convicted of operating a hospice program without a license in
27 any jurisdiction;
28 (5) an insufficient number of staff with the training, experience, or
29 judgment to provide adequate hospice care;
30 (6) committed fraud, deceit, misrepresentation, or an offense involving
31 dishonesty associated with the license application or with the operation of a hospice

1 program in any jurisdiction; or

2 (7) violated this chapter or a regulation adopted under this chapter.

3 (b) The department may, without a hearing, summarily suspend a license of
4 a hospice program if it finds that the actions or deficiencies of the program have
5 caused, or present an immediate threat of causing, serious injury to a hospice program
6 client. A licensee is entitled to a hearing before the department to appeal the summary
7 suspension within seven days after the order of suspension is issued. A licensee may
8 appeal an adverse decision of the department on an appeal of a summary suspension
9 to the superior court. A summary suspension remains in effect until the department
10 finds that the actions or deficiencies are corrected, the license is revoked, or the
11 licensee is successful in appealing the suspension.

12 (c) The department may, without a hearing, reduce a hospice license to a
13 provisional license for a period of time established by the department if the department
14 finds that the licensee is temporarily unable to comply with this chapter or is in the
15 process of becoming decertified under the Medicare program but is taking appropriate
16 steps to bring the program into compliance with this chapter or Medicare certification
17 requirements. A licensee is entitled to a hearing before the department to appeal a
18 reduction to a provisional license under this subsection within seven days after the
19 order to reduce the license is issued. A licensee may appeal an adverse decision of
20 the department on an appeal of the order reducing the license to a provisional license
21 to the superior court. A program with a provisional license under this subsection may
22 not accept new clients. If the program fails to correct its deficiencies and does not
23 successfully appeal the order reducing the license to provisional status within the
24 period stipulated in the provisional license, the department shall revoke the license.

25 **Sec. 18.18.040. Right of entry and inspection.** A duly designated employee
26 of the department may enter the premises of a hospice program that has applied for
27 a license or who is licensed under this chapter. These employees may inspect
28 documents of the hospice program to determine whether the program is in compliance
29 with this chapter and regulations adopted under this chapter. The right of entry and
30 inspection extends to premises and documents of persons whom the department has
31 reason to believe are operating a hospice program without a license.

1 **Sec. 18.18.100. Requirements for licensure.** (a) Except as provided in
2 AS 18.18.200 for volunteer hospice programs, a hospice program shall meet the
3 requirements of this section. If a hospice program meets the requirements of this
4 section and AS 18.18.010 - 18.18.040, the department shall issue a license for the
5 program.

6 (b) A hospice program shall have a clear mission statement that is consistent
7 with hospice philosophy.

8 (c) A hospice program shall have at least the following features:

9 (1) a governing body;

10 (2) an established set of admission criteria for determining appropriate
11 clients;

12 (3) a program director;

13 (4) an interdisciplinary team;

14 (5) volunteers; and

15 (6) a medical director.

16 (d) A hospice program may only provide services to a person if the person

17 (1) consents to receive those services; and

18 (2) fits the admissions criteria of the hospice program.

19 (e) Hospice services shall be delivered in accordance with a care plan
20 approved by the interdisciplinary team regardless of whether the hospice services are
21 provided by hospice program staff or by contractors. The care plan must be reviewed
22 periodically by the interdisciplinary team and revised as needed. The client, and the
23 client's family if the client desires, must be given the opportunity to participate in the
24 development of the care plan and must be informed of the opportunity to attend
25 interdisciplinary team meetings. The interdisciplinary team must consider the need for
26 at least the following services when developing the care plan:

27 (1) social services;

28 (2) nursing care;

29 (3) counseling;

30 (4) pastoral care;

31 (5) volunteer visits to provide comfort, companionship, and respite;

1 (6) bereavement services for at least one year after the death of the
2 person who is terminally ill; and
3 (7) medical services.
4 (f) Nursing services provided by a hospice program shall be provided in
5 accordance with a care plan and must be under the direction and supervision of a nurse
6 supervisor. The nurse supervisor shall
7 (1) develop nursing objectives, policies, and procedures consistent with
8 hospice philosophy;
9 (2) develop job descriptions for nursing personnel consistent with
10 hospice philosophy;
11 (3) establish staffing and on-call schedules for nursing staff to ensure
12 the availability of nursing services 24-hours a day, seven days a week; and
13 (4) develop and implement orientation and training programs for
14 nursing staff.
15 (g) Before providing a hospice service in a hospice program, a direct service
16 provider shall receive an orientation of at least four hours specific to hospice service.
17 The policy and procedures of the hospice program define the agenda of the hospice
18 orientation program. The hospice program shall document in personnel files that staff
19 members have completed the four-hour orientation. Indirect service volunteers shall
20 be oriented according to program policies. The hospice orientation program must
21 include the following subjects:
22 (1) hospice philosophy;
23 (2) personal death awareness;
24 (3) communication skills;
25 (4) personnel issues;
26 (5) identification of hospice resource people;
27 (6) stress management;
28 (7) ethics;
29 (8) stages of dying; and
30 (9) funeral arrangements.
31 (h) A hospice program shall provide an educational program that offers a

1 comprehensive overview of hospice philosophy and hospice care. A minimum of 18
2 hours of education, received within a one-year period, including four hours of
3 orientation, is required for all direct service providers delivering hospice care.
4 Documentation of completion of this program is transferable from one hospice program
5 to another. The educational program must include the following subjects:
6 (1) hospice philosophy;
7 (2) family dynamics;
8 (3) pain and symptom management;
9 (4) grief, loss, and transition;
10 (5) psychological perspectives on death and dying;
11 (6) spirituality;
12 (7) communication skills;
13 (8) volunteer roles; and
14 (9) multidisciplinary management.
15 (i) Direct service providers in a hospice program shall complete a minimum
16 of eight hours of continuing education or in-service training each year after the first
17 year, based on date of hire.
18 (j) A hospice program shall maintain, at a minimum, the following records:
19 (1) a record for each client that includes copies of the client's care
20 plan, progress notes, assessments, and a description of services provided to the client
21 and the client's family;
22 (2) minutes of governing body meetings;
23 (3) all receipts and expenditures; and
24 (4) training provided to paid staff and volunteers.
25 (k) A hospice program shall have and follow written policies and procedures
26 governing its operation, including policies relating to confidentiality, training, and
27 admissions.
28 (l) A person who enters a hospice program shall be given information
29 regarding living wills and durable health care powers of attorney.
30 (m) The hospice program shall have a functional quality assurance or
31 improvement plan in place that

1 (1) continually monitors and evaluates the care provided;
2 (2) identifies issues and potential issues;
3 (3) proposes and implements improvements; and
4 (4) reevaluates the care provided to determine if further improvement
5 is possible or needed.
6 **Article 2. Licensing of Volunteer Hospice Programs.**
7 **Sec. 18.18.200. Licensing requirements.** (a) The department shall issue a
8 license to a volunteer hospice program that complies with this section and with
9 AS 18.18.010 - 18.18.040 and 18.18.100(a), (b), (c) (1) - (3) and (5), (d), (g), and (j) -
10 (l).
11 (b) A direct service volunteer must
12 (1) submit a written application;
13 (2) undergo a screening interview and an interview after training;
14 (3) attend an 18-hour standard training program;
15 (4) submit a confidentiality statement in which the volunteer agrees to
16 follow the program's policy regarding confidentiality required by AS 18.18.100(k) and
17 (a) of this section; and
18 (5) if the volunteer will transport individuals, have proof of auto
19 insurance and a valid driver's license.
20 (c) Volunteer hospice programs shall develop and maintain policies and
21 procedures that address the following with respect to volunteers in the program:
22 (1) recruitment, retention, and dismissal;
23 (2) screening;
24 (3) orientation;
25 (4) scope of function;
26 (5) supervision;
27 (6) ongoing training and support;
28 (7) team conferencing;
29 (8) records of volunteer activities; and
30 (9) bereavement services.
31 (d) Volunteer services in a volunteer hospice program must be directed by a

1 coordinator of volunteer services who shall
2 (1) implement a direct service volunteer program;
3 (2) coordinate the orientation, education, support, and supervision of
4 direct service volunteers; and
5 (3) coordinate the use of direct service volunteers with other hospice
6 staff and community resources.
7 **Article 3. General Provisions.**
8 **Sec. 18.18.300. Individual licenses.** A program license received under this
9 chapter does not relieve an individual who is an employee, volunteer, or contractor
10 with the licensed hospice program from requirements outside this chapter pertaining
11 to licensure of the individual.
12 **Sec. 18.18.310 Sanctions.** A person who violates this chapter commits a civil
13 violation for which a fine not to exceed $100 a day of violation may be assessed by
14 a court.
15 **Sec. 18.18.320. Administrative Procedure Act.** Regulations and contested
16 cases under this chapter are governed by AS 44.62 (Administrative Procedure Act).
17 **Sec. 18.18.330. Regulations.** The department may adopt regulations to
18 implement this chapter that are consistent with the policy expressed in AS 18.18.005.
19 **Sec. 18.18.390. Definitions.** In this chapter,
20 (1) "bereavement services" means emotional support services related
21 to the death of a family member, which may include counseling, provision of written
22 material, social reorientation, and group support for up to one year following the death
23 of the client who was terminally ill;
24 (2) "care plan" means a written service delivery plan that the
25 interdisciplinary team, in conjunction with the client, shall develop to reflect the
26 changing care needs of the client;
27 (3) "client" means the person who is receiving the hospice services;
28 (4) "department" means the Department of Health and Social Services;
29 (5) "direct service provider" means employees or volunteers who
30 provide hospice services directly to a client under a hospice program;
31 (6) "family" means a spouse, primary caregiver, biological relatives,

1 and individuals with close personal ties to the client;

2 (7) "governing body" means the entity that establishes policy and is
3 legally responsible for the overall operation of a hospice program;

4 (8) "hospice philosophy" means a philosophy that is life affirming,
5 recognizes dying as a normal process of living, focuses on maintaining the quality of
6 remaining life, neither hastens nor postpones death, strengthens the client's role in
7 making informed decisions about care, and stresses the delivery of services in the least
8 restrictive setting possible and with the least amount of technology necessary by
9 volunteers and professionals who are trained to help clients with the physical, social,
10 psychological, spiritual, and emotional issues related to terminal illness so that the
11 clients can feel better prepared for the death that is to come;

12 (9) "hospice program" means a program that provides hospice services;

13 (10) "hospice services" means a range of interdisciplinary palliative and
14 supportive services provided in a home or at an inpatient facility to persons who are
15 terminally ill and those persons' families in order to meet their physical, psychological,
16 social, emotional, and spiritual needs;

17 (11) "interdisciplinary team," for a hospice program providing
18 comprehensive services, means a group comprised of at least a primary health care
19 provider, a licensed registered nurse, a social worker, a pastoral or other counselor, and
20 a volunteer coordinator or representative;

21 (12) "medical director" means a licensed physician who oversees the
22 medical components of hospice services and the interdisciplinary team;

23 (13) "nurse supervisor" means a licensed registered nurse with
24 education, experience, and training in hospice nursing care who is designated by the
25 program director to oversee nursing services for the hospice program;

26 (14) "primary health care provider" means the physician or advanced
27 nurse practitioner identified by the client or by the person authorized to make decisions
28 for the client under a durable health care power of attorney;

29 (15) "program director" means the person designated by the governing
30 body of a hospice program as responsible for the day-to-day operations of the program;

31 (16) "terminally ill" means that a person has a life expectancy of less

1 than one year, in the opinion of the person's primary physician or the medical director,
2 and is no longer receiving curative treatment;
3 (17) "volunteer" means a trained individual who works for a hospice
4 program without compensation;
5 (18) "volunteer hospice program" means a hospice program that
6 provides all direct patient care at no charge.

0-LS0602\H
Lauterbach
3/21/97

CS FOR SENATE BILL NO. 96( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST

A BILL

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21 provided by hospice program staff or by contractors. The care plan must be reviewed
22 periodically by the interdisciplinary team and revised as needed. The client, and the
23 client's family if the client desires, must be given the opportunity to participate in the
24 development of the care plan and must be informed of the opportunity to attend
25 interdisciplinary team meetings. The interdisciplinary team must consider the need for
26 at least the following services when developing the care plan:
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1 (6) bereavement services for at least one year after the death of the
2 person who is terminally ill; and
3 (7) medical services.
4 (f) Nursing services provided by a hospice program shall be provided in
5 accordance with a care plan and must be under the direction and supervision of a nurse
6 supervisor. The nurse supervisor shall
7 (1) develop nursing objectives, policies, and procedures consistent with
8 hospice philosophy;
9 (2) develop job descriptions for nursing personnel consistent with
10 hospice philosophy;
11 (3) establish staffing and on-call schedules for nursing staff to ensure
12 the availability of nursing services 24-hours a day, seven days a week; and
13 (4) develop and implement orientation and training programs for
14 nursing staff.
15 (g) Before providing a hospice service in a hospice program, a direct service
16 provider shall receive an orientation of at least four hours specific to hospice service.
17 The policy and procedures of the hospice program define the agenda of the hospice
18 orientation program. The hospice program shall document in personnel files that staff
19 members have completed the four-hour orientation. Indirect service volunteers shall
20 be oriented according to program policies. The hospice orientation program must
21 include the following subjects:
22 (1) hospice philosophy;
23 (2) personal death awareness;
24 (3) communication skills;
25 (4) personnel issues;
26 (5) identification of hospice resource people;
27 (6) stress management;
28 (7) ethics;
29 (8) stages of dying; and
30 (9) funeral arrangements.
31 (h) A hospice program shall provide an educational program that offers a

1 comprehensive overview of hospice philosophy and hospice care. A minimum of 18
2 hours of education, received within a one-year period, including four hours of
3 orientation, is required for all direct service providers delivering hospice care.
4 Documentation of completion of this program is transferable from one hospice program
5 to another. The educational program must include the following subjects:
6 (1) hospice philosophy;
7 (2) family dynamics;
8 (3) pain and symptom management;
9 (4) grief, loss, and transition;
10 (5) psychological perspectives on death and dying;
11 (6) spirituality;
12 (7) communication skills;
13 (8) volunteer roles; and
14 (9) multidisciplinary management.
15 (i) Direct service providers in a hospice program shall complete a minimum
16 of eight hours of continuing education or in-service training each year after the first
17 year, based on date of hire.
18 (j) A hospice program shall maintain, at a minimum, the following records:
19 (1) a record for each client that includes copies of the client's care
20 plan, progress notes, assessments, and a description of services provided to the client
21 and the client's family;
22 (2) minutes of governing body meetings;
23 (3) all receipts and expenditures; and
24 (4) training provided to paid staff and volunteers.
25 (k) A hospice program shall have and follow written policies and procedures
26 governing its operation, including policies relating to confidentiality, training, and
27 admissions.
28 (l) A person who enters a hospice program shall be given information
29 regarding living wills and durable health care powers of attorney.
30 (m) The hospice program shall have a functional quality assurance or
31 improvement plan in place that

1 (1) continually monitors and evaluates the care provided;
2 (2) identifies issues and potential issues;
3 (3) proposes and implements improvements; and
4 (4) reevaluates the care provided to determine if further improvement
5 is possible or needed.
6 **Article 2. Licensing of Volunteer Hospice Programs.**
7 **Sec. 18.18.200. Licensing requirements.** (a) The department shall issue a
8 license to a volunteer hospice program that complies with this section and with
9 AS 18.18.010 - 18.18.040 and 18.18.100(a), (b), (c) (1) - (3) and (5), (d), (g), and (j) -
10 (l).
11 (b) A direct service volunteer must
12 (1) submit a written application;
13 (2) undergo a screening interview and an interview after training;
14 (3) attend an 18-hour standard training program;
15 (4) submit a confidentiality statement in which the volunteer agrees to
16 follow the program's policy regarding confidentiality required by AS 18.18.100(k) and
17 (a) of this section; and
18 (5) if the volunteer will transport individuals, have proof of auto
19 insurance and a valid driver's license.
20 (c) Volunteer hospice programs shall develop and maintain policies and
21 procedures that address the following with respect to volunteers in the program:
22 (1) recruitment, retention, and dismissal;
23 (2) screening;
24 (3) orientation;
25 (4) scope of function;
26 (5) supervision;
27 (6) ongoing training and support;
28 (7) team conferencing;
29 (8) records of volunteer activities; and
30 (9) bereavement services.
31 (d) Volunteer services in a volunteer hospice program must be directed by a

1 coordinator of volunteer services who shall
2 (1) implement a direct service volunteer program;
3 (2) coordinate the orientation, education, support, and supervision of
4 direct service volunteers; and
5 (3) coordinate the use of direct service volunteers with other hospice
6 staff and community resources.
7 **Article 3. General Provisions.**
8 **Sec. 18.18.300. Individual licenses.** A program license received under this
9 chapter does not relieve an individual who is an employee, volunteer, or contractor
10 with the licensed hospice program from requirements outside this chapter pertaining
11 to licensure of the individual.
12 **Sec. 18.18.310 Sanctions.** A person who violates this chapter commits a civil
13 violation for which a fine not to exceed $100 a day of violation may be assessed by
14 a court.
15 **Sec. 18.18.320. Administrative Procedure Act.** Regulations and contested
16 cases under this chapter are governed by AS 44.62 (Administrative Procedure Act).
17 **Sec. 18.18.330. Regulations.** The department may adopt regulations to
18 implement this chapter that are consistent with the policy expressed in AS 18.18.005.
19 **Sec. 18.18.390. Definitions.** In this chapter,
20 (1) "bereavement services" means emotional support services related
21 to the death of a family member, including counseling, provision of written material,
22 social reorientation, and group support for up to one year following the death of the
23 client who was terminally ill;
24 (2) "care plan" means a written service delivery plan that the
25 interdisciplinary team, in conjunction with the client, shall develop to reflect the
26 changing care needs of the client;
27 (3) "client" means the person who is receiving the hospice services;
28 (4) "department" means the Department of Health and Social Services;
29 (5) "direct service provider" means employees or volunteers who
30 provide hospice services directly to a client under a hospice program;
31 (6) "family" means a spouse, primary caregiver, biological relatives,

1 and individuals with close personal ties to the client;

2 (7) "governing body" means the entity that establishes policy and is
3 legally responsible for the overall operation of a hospice program;

4 (8) "hospice philosophy" means a philosophy that is life affirming,
5 recognizes dying as a normal process of living, focuses on maintaining the quality of
6 remaining life, neither hastens nor postpones death, strengthens the client's role in
7 making informed decisions about care, and stresses the delivery of services in the least
8 restrictive setting possible and with the least amount of technology necessary by
9 volunteers and professionals who are trained to help clients with the physical, social,
10 psychological, spiritual, and emotional issues related to terminal illness so that the
11 clients can feel better prepared for the death that is to come;

12 (9) "hospice program" means a program that provides hospice services;

13 (10) "hospice services" means a range of interdisciplinary palliative and
14 supportive services provided in a home or at an inpatient facility on a 24-hours-a-day,
15 seven-days-a-week basis to persons who are terminally ill and those persons' families
16 in order to meet their physical, psychological, social, emotional, and spiritual needs;

17 (11) "interdisciplinary team," for a hospice program providing
18 comprehensive services, means a group comprised of at least a primary health care
19 provider, a licensed registered nurse, a social worker, a pastoral or other counselor, and
20 a volunteer coordinator or representative;

21 (12) "medical director" means a licensed physician who oversees the
22 medical components of hospice services and the interdisciplinary team;

23 (13) "nurse supervisor" means a licensed registered nurse with
24 education, experience, and training in hospice nursing care who is designated by the
25 program director to oversee nursing services for the hospice program;

26 (14) "primary health care provider" means the physician or advanced
27 nurse practitioner identified by the client or by the person authorized to make decisions
28 for the client under a durable health care power of attorney;

29 (15) "program director" means the person designated by the governing
30 body of a hospice program as responsible for the day-to-day operations of the program;

31 (16) "terminally ill" means that a person has a life expectancy of less

1 than one year, in the opinion of the person's primary physician or the medical director,
2 and is no longer receiving curative treatment;
3 (17) "volunteer" means a trained individual who works for a hospice
4 program without compensation;
5 (18) "volunteer hospice program" means a hospice program that
6 provides all direct patient care at no charge.

0-LS0602\F
Lauterbach
3/10/97

CS FOR SENATE BILL NO. 96( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST

A BILL

FOR AN ACT ENTITLED

1 "An Act regulating hospice care."

2 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

3 * Section 1. AS 18 is amended by adding a new chapter to read:

4 Chapter 18. Hospice Care Programs.

5 Article 1. Licensing of Hospice Programs.

6 **Sec. 18.18.010. License required.** A person, including a partnership,
7 association, or corporation, may not represent itself as a hospice program or operate
8 a hospice program unless the person, partnership, association, or corporation has
9 obtained a license from the department.

10 **Sec. 18.18.020. Issuance and renewal of license.** (a) Upon receiving an
11 application and fee, if any, for a license under this chapter, the department shall issue
12 a license if the applicant meets the applicable requirements of this chapter.

13 (b) If an applicant under (a) of this section does not meet the applicable
14 requirements but makes continued efforts to comply with them and any noncompliance
15 does not directly affect the safety of clients, the department may issue a temporary or

1 provisional license that is valid for a reasonable period of time, as determined by the
2 department.
3 (c) A license under this chapter shall be issued in the name of the person,
4 agency, or other entity specified in the application and is not transferable or assignable
5 without the written approval of the department.
6 (d) The department shall, by regulation, establish the application fee, license
7 fee, length of time that a license is valid, and the standards for license renewal. A
8 license is not renewable during the time it has been suspended or revoked under this
9 chapter.
10 **Sec. 18.18.030. Denial, suspension, or revocation of license.** (a) The
11 department may deny a license, reduce a license to a provisional license, or revoke a
12 license if the department finds that the applicant or licensee, as appropriate, or the
13 program director or medical director of the applicant or licensee, as applicable, has
14 (1) endangered the health, safety, or welfare of a client;
15 (2) a history of deficiencies in quality of care;
16 (3) had a license to operate a hospice program suspended or revoked
17 in another licensing jurisdiction for a reason other than failure to pay a licensing fee;
18 (4) been convicted of operating a hospice program without a license in
19 any jurisdiction;
20 (5) an insufficient number of staff with the training, experience, or
21 judgment to provide adequate hospice care;
22 (6) committed fraud, deceit, misrepresentation, or an offense involving
23 dishonesty associated with the license application or with the operation of a hospice
24 program in any jurisdiction; or
25 (7) violated this chapter or a regulation adopted under this chapter.
26 (b) The department may, without a hearing, summarily suspend a license of
27 a hospice program if it finds that the actions or deficiencies of the program have
28 caused, or present an immediate threat of causing, serious injury to the public health,
29 safety, or welfare. A licensee is entitled to a hearing before the department to appeal
30 the summary suspension within seven days after the order of suspension is issued. A
31 licensee may appeal an adverse decision of the department on an appeal of a summary

1 suspension to the superior court. A summary suspension remains in effect until the
2 department finds that the actions or deficiencies are corrected, the license is revoked,
3 or the licensee is successful in appealing the suspension.
4 (c) The department may, without a hearing, reduce a hospice license to a
5 provisional license for a period of time established by the department if the department
6 finds that the licensee is temporarily unable to comply with this chapter or is in the
7 process of becoming decertified under the Medicare program but is taking appropriate
8 steps to bring the program into compliance with this chapter or Medicare certification
9 requirements. A licensee is entitled to a hearing before the department to appeal a
10 reduction to a provisional license under this subsection within seven days after the
11 order to reduce the license is issued. A licensee may appeal an adverse decision of
12 the department on an appeal of the order reducing the license to a provisional license
13 to the superior court. A program with a provisional license under this subsection may
14 not accept new clients. If the program fails to correct its deficiencies and does not
15 successfully appeal the order reducing the license to provisional status within the
16 period stipulated in the provisional license, the department shall revoke the license.
17 **Sec. 18.18.040. Right of entry and inspection.** A duly designated employee
18 of the department may enter the premises of a hospice program that has applied for
19 a license or who is licensed under this chapter. These employees may inspect
20 documents of the hospice program to determine whether the program is in compliance
21 with this chapter and regulations adopted under this chapter. The right of entry and
22 inspection extends to premises and documents of persons whom the department has
23 reason to believe are operating a hospice program without a license.
24 **Sec. 18.18.100. Requirements for licensure.** (a) The department shall adopt
25 regulations that specify the requirements for licensure under this chapter. The
26 regulations must include the requirements of this section for hospice programs that are
27 not volunteer hospice programs.
28 (b) A hospice program shall have a clear mission statement that is consistent
29 with hospice philosophy.
30 (c) A hospice program shall have at least the following features:
31 (1) a governing body;

1 (2) an established set of admission criteria for determining appropriate
2 clients;
3 (3) a program director;
4 (4) an interdisciplinary team;
5 (5) volunteers; and
6 (6) a medical director.
7 (d) A hospice program may only provide services to a person if the person
8 (1) consents to receive those services; and
9 (2) fits the admissions criteria of the hospice program.
10 (e) Hospice services shall be delivered in accordance with a care plan
11 approved by the interdisciplinary team regardless of whether the hospice services are
12 provided by hospice program staff or by contractors. The care plan must be reviewed
13 periodically by the interdisciplinary team and revised as needed. The client, and the
14 client's family if the client desires, must be given the opportunity to participate in the
15 development of the care plan and must be informed of the opportunity to attend
16 interdisciplinary team meetings. The interdisciplinary team must consider the need for
17 at least the following services when developing the care plan:
18 (1) social services;
19 (2) nursing care;
20 (3) counseling;
21 (4) pastoral care;
22 (5) volunteer visits to provide comfort, companionship, and respite;
23 (6) bereavement services for at least one year after the death of the
24 person who is terminally ill; and
25 (7) medical services.
26 (f) Nursing services provided by a hospice program shall be provided in
27 accordance with a care plan and must be under the direction and supervision of a nurse
28 supervisor. The nurse supervisor shall
29 (1) develop nursing objectives, policies, and procedures consistent with
30 hospice philosophy;
31 (2) develop job descriptions for nursing personnel consistent with

1 hospice philosophy;

2 (3) establish staffing and on-call schedules for nursing staff to ensure
3 the availability of nursing services 24-hours a day, seven days a week; and

4 (4) develop and implement orientation and training programs for
5 nursing staff.

6 (g) Before providing a hospice service in a hospice program, a direct service
7 provider shall receive an orientation of at least four hours specific to hospice service.
8 The policy and procedures of the hospice program define the agenda of the hospice
9 orientation program. The hospice program shall document in personnel files that staff
10 members have completed the four-hour orientation. Indirect service volunteers shall
11 be oriented according to program policies. The hospice orientation program must
12 include the following subjects:

13 (1) hospice philosophy;

14 (2) personal death awareness;

15 (3) communication skills;

16 (4) personnel issues;

17 (5) identification of hospice resource people;

18 (6) stress management;

19 (7) ethics;

20 (8) stages of dying; and

21 (9) funeral arrangements.

22 (h) A hospice program shall provide an educational program that offers a
23 comprehensive overview of hospice philosophy and hospice care. A minimum of 18
24 hours of education, received within a one-year period, including four hours of
25 orientation, is required for all direct service providers delivering hospice care.
26 Documentation of completion of this program is transferable from one hospice program
27 to another. The educational program must include the following subjects:

28 (1) hospice philosophy;

29 (2) family dynamics;

30 (3) pain and symptom management;

31 (4) grief, loss, and transition;

(5) psychological perspectives on death and dying;

(6) spirituality;

(7) communication skills;

(8) volunteer roles; and

(9) multidisciplinary management.

(i) Direct service providers in a hospice program shall complete a minimum of eight hours of continuing education or in-service training each year after the first year, based on date of hire.

(j) A hospice program shall maintain, at a minimum, the following records:

(1) a record for each client that includes copies of the client's care plan, progress notes, assessments, and a description of services provided to the client and the client's family;

(2) minutes of governing body meetings;

(3) all receipts and expenditures; and

(4) training provided to paid staff and volunteers.

(k) A hospice program shall have and follow written policies and procedures governing its operation, including policies relating to confidentiality, training, and admissions.

(l) A person who enters a hospice program shall be given information regarding living wills and durable health care powers of attorney.

(m) The hospice program shall have a functional quality assurance or improvement plan in place that

(1) continually monitors and evaluates the care provided;

(2) identifies issues and potential issues;

(3) proposes and implements improvements; and

(4) reevaluates the care provided to determine if further improvement is possible or needed.

Article 2. Licensing of Volunteer Hospice Programs.

Sec. 18.18.200. Licensing requirements. (a) A volunteer hospice program must comply with this section and with AS 18.18.010 - 18.18.040 and 18.18.100(a), (b), (c) (1) - (3) and (5), (d), (g), and (j) - (l).

1 (b) At a minimum, a direct service volunteer must
2 (1) submit a written application;
3 (2) undergo a screening interview and an interview after training;
4 (3) attend an 18-hour standard training program;
5 (4) submit a confidentiality statement in which the volunteer agrees to
6 follow the program's policy regarding confidentiality required by AS 18.18.100(k) and
7 (a) of this section; and
8 (5) if the volunteer will transport individuals, have proof of auto
9 insurance and a valid driver's license.
10 (c) Volunteer hospice programs shall develop and maintain policies and
11 procedures that address the following with respect to volunteers in the program:
12 (1) recruitment, retention, and dismissal;
13 (2) screening;
14 (3) orientation;
15 (4) scope of function;
16 (5) supervision;
17 (6) ongoing training and support;
18 (7) team conferencing;
19 (8) records of volunteer activities; and
20 (9) bereavement services.
21 (d) Volunteer services in a volunteer hospice program must be directed by a
22 coordinator of volunteer services who shall
23 (1) implement a direct service volunteer program;
24 (2) coordinate the orientation, education, support, and supervision of
25 direct service volunteers; and
26 (3) coordinate the use of direct service volunteers with other hospice
27 staff and community resources.
28 **Article 3. General Provisions.**
29 **Sec. 18.18.300. Individual licenses.** A program license received under this
30 chapter does not relieve an individual who is an employee, volunteer, or contractor
31 with the licensed hospice program from requirements outside this chapter pertaining

1 to licensure of the individual.

2 **Sec. 18.18.310 Sanctions.** A person who violates this chapter commits a civil
3 violation for which a fine not to exceed $100 a day of violation may be assessed by
4 a court.

5 **Sec. 18.18.320. Administrative Procedure Act.** Regulations and contested
6 cases under this chapter are governed by AS 44.62 (Administrative Procedure Act).

7 **Sec. 18.18.390. Definitions.** In this chapter,

8 (1) "bereavement services" means emotional support services related
9 to the death of a family member, including counseling, provision of written material,
10 social reorientation, and group support for up to one year following the death of the
11 client who was terminally ill;

12 (2) "care plan" means a written service delivery plan that the
13 interdisciplinary team, in conjunction with the client, shall develop to reflect the
14 changing care needs of the client;

15 (3) "client" means the person who is receiving the hospice services;

16 (4) "department" means the Department of Health and Social Services;

17 (5) "direct service provider" means employees or volunteers who
18 provide hospice services directly to a client under a hospice program;

19 (6) "family" means a spouse, primary caregiver, biological relatives,
20 and individuals with close personal ties to the client;

21 (7) "governing body" means the entity that establishes policy and is
22 legally responsible for the overall operation of a hospice program;

23 (8) "hospice philosophy" means a philosophy that is life affirming,
24 recognizes dying as a normal process of living, focuses on maintaining the quality of
25 remaining life, neither hastens nor postpones death, strengthens the client's role in
26 making informed decisions about care, and stresses the delivery of services in the least
27 restrictive setting possible and with the least amount of technology necessary by
28 volunteers and professionals who are trained to help clients with the physical, social,
29 psychological, spiritual, and emotional issues related to terminal illness so that the
30 clients can feel better prepared for the death that is to come;

31 (9) "hospice program" means a program that provides hospice services;

1 (10) "hospice services" means a range of interdisciplinary palliative and
2 supportive services provided in a home or at an inpatient facility on a 24-hours-a-day,
3 seven-days-a-week basis to persons who are terminally ill and those persons' families
4 in order to meet their physical, psychological, social, emotional, and spiritual needs;
5 (11) "interdisciplinary team," for a hospice program providing
6 comprehensive services, means a group comprised of at least a primary health care
7 provider, a licensed registered nurse, a social worker, a pastoral or other counselor, and
8 a volunteer coordinator or representative;
9 (12) "medical director" means a licensed physician who oversees the
10 medical components of hospice services and the interdisciplinary team;
11 (13) "nurse supervisor" means a licensed registered nurse with
12 education, experience, and training in hospice nursing care who is designated by the
13 program director to oversee nursing services for the hospice program;
14 (14) "primary health care provider" means the physician or advanced
15 nurse practitioner identified by the client or by the person authorized to make decisions
16 for the client under a durable health care power of attorney;
17 (15) "program director" means the person designated by the governing
18 body of a hospice program as responsible for the day-to-day operations of the program;
19 (16) "terminally ill" means that a person has a life expectancy of less
20 than one year, in the opinion of the person's primary physician or the medical director,
21 and is no longer receiving curative treatment;
22 (17) "volunteer" means a trained individual who works for a hospice
23 program without compensation;
24 (18) "volunteer hospice program" means a hospice program that
25 provides all direct patient care at no charge.

Alaska State Legislature

Sen. Wilken

Senate

Official Business

State Capitol
Juneau, AK. 99801-1182

Rules Committee

COMMITTEE SUBSTITUTE for SENATE BILL 96
SPONSOR STATEMENT

Senate Bill 96 will provide for licensing of hospice care programs in Alaska, ensuring that terminally ill persons receive comfort, support, and care consistent with hospice philosophy and concepts through a uniform level of services, whether they recieve hospice services from a volunteer hospices, or from certified, professional, or for-profit. There are no federal regulation or licensing requirements for either type of hospice program. As of the January 1997, forty (40) states are licensing or regulating hospice programs. Of the ten (10) states without hospice licensing or regulation, five (5) have laws or regulations pending. Appropriate licensing and regulation of all hospice programs in Alaska will assure consumers of consistent standards in the delivery of hospice services.

Hospice is a unique component of the health care delivery system, one that has evolved over the past 20 years in the United States. Hospice provides care and support for people with terminal illness. The goal of hospice care is to enable patients to live an alert, pain-free life and to manage symptoms so the last weeks and months of life may be spent in dignity and peace. One out of every three people who die of cancer or AIDS in this country are served by a hospice program.

Annual growth in hospice programs averaged about eight per cent (8%) in the early '90s. In the last five (5) years growth has averaged seventeen per cent (17%). Hospice services are provided through a variety of means, including independent community-based organizations, divisions of hospitals or home-health services, and government agencies. Rapid growth of hospice programs is due to increased demand for home care services, the desire of terminally ill persons to keep control over the remainder of their lives, and a trend towards reimbursement for home-care services. ***Consumers need to be aware of specific characteristics that differentiate hospice from other health care providers. Hospice offers comfort and care, not curative treatment.*** Hospice addresses emotional, spiritual, and social needs in addition to physical needs. Hospice considers the patient and loved ones as the unit of care. ***Hospice affirms life and regards dying as a normal process, seeking neither to hasten nor postpone death.*** Hospice care extends beyond a patient's death to include bereavement care for grieving family members.

Fear of painful suffering, of abandonment, and of losing control are primary concerns of people experiencing terminal illness. Hospice care is designed to address these concerns by providing support, care, and needed services to help the terminally ill *live their lives* in *maximal comfort and control.*

Passage of SB 96 will standardize hospice care and help to guarantee Alaskans access to quality hospice care from both volunteer and certified hospice programs.

(revised 8 April 1997)

Official Business

Alaska State Legislature

Senate

State Capitol
Juneau, AK. 99801-1182

Rules Committee

MEMORANDVM.

TO: Senator Wilken, Chairman
Senate HESS Committee

FROM: Benjamin Brown, Legislative Aide
to Senator Kelly

DATE: 8 April 1997

IN RE: *newly revised* sectional analysis of SB 96 (LS0602/K)

A revised summary by section of CSSB 96 (work draught) follows. This bill adds a new chapter, entitled Hospice Care Programs, to Title 18 of Alaska Statutes. Substantial changes have been made to the bill in its time with the Senate HESS Committee.

Please note that a sectional analysis is not generally considered to be the most authoritative interpretation of a bill; the bill itself is the best statement of its purposes and effects.

<u>Section 1</u> remains SB 96's only section. It adds Chapter 18 to Title 18 of Alaska Statutes. Chapter 18 contains three articles, the first of which declares the State's policy on licensing hospices (a policy that explicitly recognizes the limited resources of volunteer hospice programs), and sets out standards for hospice programs that are colloquially referred to as certified, professional, or for-profit. Article II establishes a substantially smaller set of standards for volunteer hospice programs. Article III clarifies the need for individual licensing, sets out terms for sanctions and regulatory authority, and defines a number of terms germane to the regulation of hospice care. An analysis of each of these three articles follows.

1. *Article I* begins by making a clear statement of the State's statutory policy on hospices, which provides that licensing by the

licensing and the licensing process, and specified parts of AS 18.18.100. It requires volunteer hospice programs to have a minimum structure that includes a mission statement, admission criteria, a director, and volunteers.

Article 2 applies the same standards regarding client consent and use of admission criteria to volunteer hospice programs as to certified ones. It calls for volunteer direct service providers to get four (4) hours of hospice service orientation. It mandates minimum record-keeping and written policies and procedures for volunteer hospice organizations, specifically volunteer policies and procedures. It necessitates provision of information about living wills and durable health care powers of attorney to volunteer hospice clients. Finally, it standardizes the co-ordination of volunteers.

3. *Article 3* specifies that certified or volunteer hospice program licensing does not remove or mitigate individual licensing requirements from any employee, volunteer, or contractor working with a hospice program. It allows for civil penalties for violations of Chapter 18. It makes the licensing process and regulations subject to the Administrative Procedures Act, and enables DH&SS to adopt regulations that specifically implement the requirements of the statute, while reflecting the policy statement contained in 18.18.005. Finally, *Article 3* defines numerous terms used throughout the bill.

Senator Wilken

Alaska State Legislature

Senate

Official Business

State Capitol
Juneau, AK. 99801-1182

Rules Committee
CS *SENATE BILL 96* (HES)
SPONSOR STATEMENT

Senate Bill 96 will provide for licensing of hospice care programs in Alaska, ensuring that terminally ill persons receive comfort, support, and care consistent with hospice philosophy and concepts through a uniform level of services. There are no federal regulation or licensing requirements for either certified or volunteer hospice programs. As of the January 1997, forty (40) states are licensing or regulating hospice programs. Of the ten (10) states without hospice licensing or regulation, five (5) have laws or regulations pending. Appropriate licensing and regulation of volunteer and certified hospice programs in Alaska will assure consumers of consistent standards in the delivery of hospice services.

Hospice is a unique component of the health care delivery system, one that has evolved over the past 20 years in the United States. Hospice provides care and support for people with terminal illness. The goal of hospice care is to enable patients to live an alert, pain-free life and to manage symptoms so the last weeks and months of life may be spent in dignity and peace. One out of every three people who die of cancer or AIDS in this country are served by a hospice program.

Annual growth in hospice programs averaged about eight per cent (8%) in the early '90s. In the last five (5) years growth has averaged seventeen per cent (17%). Hospice services are provided through a variety of means, including independent community-based organizations, divisions of hospitals or home-health services, and government agencies. Rapid growth of hospice programs is due to increased demand for home care services, the desire of terminally ill persons to keep control over the remainder of their lives, and a trend towards reimbursement for home-care services. *Consumers need to be aware of specific characteristics that differentiate hospice from other health care providers. Hospice offers comfort and care, not curative treatment.* Hospice addresses emotional, spiritual, and social needs in addition to physical needs. Hospice considers the patient and loved ones as the unit of care. *Hospice affirms life and regards dying as a normal process, seeking neither to hasten nor postpone death.* Hospice care extends beyond a patient's death to include bereavement care for grieving family members.

Fear of painful suffering, of abandonment, and of losing control are primary concerns of people experiencing terminal illness. Hospice care is designed to address these concerns by providing support, care, and needed services to help the terminally ill *live their lives* in *maximal comfort and control.*

Passage of SB 96 will standardize hospice care and help to guarantee Alaskans access to quality hospice care from both volunteer and certified hospice programs.

(revised 19 March 1997)

Alaska State Legislature

Senate

Official Business

State Capitol
Juneau, AK. 99801-1182

Rules Committee

MEMORANDVM.

TO: Senator Wilken, Chairman
Senate HESS Committee

FROM: Benjamin Brown, Legislative Aide
to Senator Kelly

DATE: 19 March 1997

IN RE: revised sectional analysis of SB 96 (LS0602/F)

A revised summary by section of Senate Bill 96 follows. This bill adds a new chapter, entitled Hospice Care Programs, to Title 18 of Alaska Statutes. Several changes have been made to the bill since it was last reviewed by the HESS Committee as version LS0602/E.

Please note that a sectional analysis is not generally considered to be the most authoritative interpretation of a bill; the bill itself is the best statement of its purposes and effects.

Section 1 remains SB 96's only section. It adds Chapter 18 to Title 18 of Alaska Statutes. Chapter 18 contains three articles, the first of which sets out standards for certified, professional hospice programs. Article II establishes a shorter set of standards for volunteer hospice programs. Article III clarifies individual licensing requirements and defines a number of terms germane to the regulation of hospice care. An analysis of each of these three articles follows.

1. *Article 1* sets out parameters for licensing certified hospice programs and mandates that all hospice programs must be licensed to operate in Alaska. It enables the Department of Health & Social Services (DH&SS) to issue licenses, temporary licenses, and provisional licenses, and to deny, suspend, and revoke such licenses.

health care powers of attorney to volunteer hospice clients. Finally, it standardizes the co-ordination of volunteers.

3. *Article 3* specifies that certified or volunteer hospice program licensing does not remove or mitigate individual licensing requirements from any employee, volunteer, or contractor working with a hospice program. It allows for civil penalties for violations of Chapter 18. It makes the licensing process and regulations subject to the Administrative Procedures Act. Finally, *Article 3* defines numerous terms used throughout the bill.

Hospice to bring comfort to scene of death

By SARANA SCHELL
Fairbanks Daily News-Miner

FAIRBANKS — As a funeral director, Mike Hawkins was often the last to leave the scene of a death.

Years ago, as he was about to leave the home of a man whose wife had just committed suicide, he looked back. He knew it would be several hours before the man's family would arrive.

"I saw that elderly man standing on his porch in a bloodied robe, and I couldn't leave him. I just couldn't," Hawkins said. He went back and called a minister friend to come wait with the man.

Hawkins has called other ministers over the years to comfort people left alone by death. The ministers would come, but they had no training in crisis intervention. He was sure the service could be provided in a less haphazard way.

Then, last summer, a call to Hospice of the Tanana Valley became the catalyst for a team of first responders — the Emergency Grief and Bereavement Response Team — who will comfort people who have suddenly lost a loved one.

"A tour company called us to say that a couple had been touring in Denali Park, when the man died of a heart attack," said Sally Fenno of Hospice.

Hospice found someone to stay with the woman, who was from the Lower 48, until she could take a plane home, said Fenno, the bereavement services coordinator for Hospice.

At first, Hospice thought the emergency response volunteers for visitors could be an offshoot of longer-term bereavement counseling. But Hawkins, a member of the Hospice board of directors, helped broaden the effort to include regular members of the community.

It became clear there was a need for a separate program.

"Fairbanks has an awful lot of people who have families somewhere else, and a lot of visitors come through," Fenno said. "Many visitors are older."

Hospice is now training volunteers to be part of the Emergency Grief and Bereavement Response Team, on call 24 hours a day. A volunteer can quickly be at a grieving person's side, help them with practical matters such as making phone calls, and wait there until family or close friends show up.

"They may ask, do you have your address book with you? Is there anyone you want me to call?" Fenno said, or even, "Do you want me to dial the number?"

Visitors especially may need help setting up arrangements.

Please see Page B-2, FAIRBANKS

FROM the 'Anchorage Daily News' 17 March '97 p. B2

FAIRBANKS: Hospice aims to fill need

Continued from Page B-1

They may not know, for example, what to do with the body before it can be shipped out.

Once the training of volunteers is complete, Hospice will send letters to area hotels, park agencies, fire and police departments and other groups, announcing the service. Hospice will give them a pager number to call, Fenno said.

Sgt. Mike Corkill of the Alaska State Troopers said he looked forward to hearing from Hospice about the program.

"It's our most difficult job to tell people they've lost a loved one," Corkill said. "Although my folks have got some training in dealing with this, and are sensitive to people, Hospice works with this on a regular basis. I can see a lot of good coming from this."

Ingrid Hinde came close to being alone when her husband, Fairbanks newsman Chuck Hinde, died of a heart attack in the middle of a June night in 1995.

"Luckily I had a friend of my husband's in town," Hinde said, "but otherwise I would've been totally stranded."

Now Hinde, a Hospice volunteer, is training to be an emergency bereavement volunteer. The goal is to make a traumatic experience a little less traumatic, she said.

"It's way out on the cutting edge," she said. "There isn't any other program out there like it."

The group is preparing for the coming tourist season, Hinde said, by composing a list of people who speak different languages or who can provide grieving visitors with a short-term place to stay.

Alaska State Legislature

Senate

Official Business

State Capitol
Juneau, AK. 99801-1182

Rules Committee
SENATE BILL 96
SPONSOR STATEMENT

Senate Bill 96 will provide for licensing of hospice care programs in Alaska, ensuring that terminally ill persons receive comfort, support, and care consistent with hospice philosophy and concepts through a uniform level of services. There is no federal regulatory or mandatory licensing of hospice programs, but thirty-eight (38) states presently have state licensing laws for hospice programs. Of the states with no hospice licensing laws, six (6) have licensing laws pending. The licensing of hospice programs in Alaska will assure consumers of consistent standards in the delivery of hospice services.

Hospice is a unique aspect of the health care delivery system which has evolved over the past 20 years in the United States. Hospice provides care and support for people with terminal illness. The goal of hospice care is to enable patients to live an alert, pain-free life and to manage symptoms so the last weeks and months of life may be spent in dignity and peace. One out of every three people who die of cancer or AIDS in this country are served by a hospice program.

Annual growth in hospice programs averaged about eight per cent in the early '90s. In the last five years growth has averaged seventeen per cent. Hospice services are provided through a variety of organizational structures including independent community-based organizations, divisions of hospitals or home-health agencies, and government organizations. Rapid growth of hospice programs is due to increased demand for home care services, the desire of terminally ill persons to keep control over the remainder of their lives, and a trend towards reimbursement for home-care services. Consumers need to be aware of specific characteristics that differentiate hospice from other health care providers. Hospice offers comfort and care, not curative treatment. Hospice addresses emotional, spiritual, and social needs in addition to physical needs. Hospice considers the patient *and loved ones* as the unit of care. Hospice affirms life and regards dying as a normal process, seeking neither to hasten nor postpone death. Hospice care extends beyond a patient's death to include bereavement care for grieving family members.

Fear of painful suffering, of abandonment, and of losing control are primary concerns of men and women experiencing terminal illness. Hospice care is designed to address these concerns by providing support, care, and needed services to help the terminally ill *live their lives* in *maximal comfort and control.*

Passage of SB 96 will standardize hospice care and guarantee the Alaskan public the opportunity to access quality hospice care.

Alaska State Legislature

Senate

Official Business

State Capitol
Juneau, AK. 99801-1182

Rules Committee

MEMORANDVM.

TO: Senator Kelly, Chairman
Senate Rules Committee

FROM: Benjamin Brown, Legislative Aide

DATE: 22 February 1997

IN RE: sectional analysis of SB 96

A summary, by section, of Senate Bill 96 follows. This bill adds a new chapter, entitled Hospice Care Programs, to Title 18 of Alaska Statutes. Please note that a sectional analysis is not generally considered to be the most authoritative interpretation of a bill; the bill itself is the best statement of its purposes and effects.

<u>Section 1</u> is SB 96's only section. It adds Chapter 18 to Title 18 of Alaska Statutes. Chapter 18 contains three articles, each of which pertains to a different aspect of regulating hospice care. An analysis of each of the three articles follows.

1. *Article 1* sets out parameters for licensing of hospice programs. It mandates that any and all hospice programs must be licensed to operate in Alaska. It sets out that the Department of Health & Social Services (DH&SS) can issue licenses and conditional licenses, and can revoke or suspend licenses so issued. It specifies that Medicare-certified hospice programs automatically meet this bill's criteria, and are eligible to receive a state hospice license. It gives DH&SS the right to enter and inspect hospice facilities and access their records, although a warrant must obtained if the facility refuses permission to DH&SS.

Article 1 continues by outlining specific requirements a hospice must meet in order to get a license, including a mission statement, a governing body, admission criteria, a program director, an interdisciplinary team, volunteers, and a medical director. It

requires a hospice program to adopt admission criteria for potential clients. It mandates that services be provided in accordance with a care plan, and lists services that the interdisciplinary team must consider when crafting a care plan. It sets out that nursing services be provided only under the auspices of a nurse supervisor.

Article 1 provides that direct service providers go through orientation before providing hospice services, requires direct service providers to complete an educational overview of hospice philosophy and care, and mandates continuing education or in-service training over time. It further requires a minimal level of record-keeping and written policies and procedures. *Article 1* necessitates provision of information about living wills and durable health care powers of attorney to hospice clients. Finally, the first article in Chapter 18 of Title 18 mandates quality assurance and improvement planning, and requires Medicare certification of a facility used for an inpatient hospice program as a condition of state licensing.

2. *Article 2* sets out standards for volunteer hospice programs, primarily the things direct service volunteers must do in order to prepare to provide hospice services. It mandates policies and procedures dealing with direct service volunteers, including co-ordination of such volunteer efforts. *Article 2* also requires volunteer programs to meet the "relevant" requirements of *Article 1*.

3. *Article 3* specifies that program licensing under Chapter 18 of Title 18 does not remove or mitigate individual licensing requirements from any employee, volunteer, or contractor working with a hospice program. It allows for civil penalties for violations of Chapter 18. Finally, *Article 3* defines numerous terms used throughout the bill.

Proposed 4/9/97
by Sen Ward
defeated 3-2

AMENDMENT 1
SB 96 – Regulation of Hospice Care

1. Eliminate Article 2 in its entirety.

2. Add in place of Article 2;

   "The provisions of this bill are to apply to Certified and Resident Hospices only and not to Volunteer Hospice Programs."

3. Add under AS 18.18.390 Definitions:

   Line 17, "volunteer" means a trained individual who works for a hospice program without compensation.

   Line 18, "volunteer hospice program" means a hospice program that provides all direct patient care at no charge.

February 26, 1997

Senator Tim Kelly
State Capitol
Juneau, Alaska 99801-1182
Mailstop: 3100

Dear Senator Kelly:

After careful review of SB 96, we would like to inform you the Department of Health & Social Services (DHSS) supports the intent of this Bill, however we are providing you with recommendations for changes.

We have seen the Medicare certified hospice programs grow in Alaska over the last three years. The first certified program came in November, 1993, and since then two others have been certified. In addition, we are aware of at least 7 volunteer programs now functioning within the State. It is our understanding that the impetus for this legislation is a result of concerns which have been raised as to how the integrity of the hospice philosophy and quality of care can be preserved in a climate where vast fluctuations in the health care industry are occurring on a daily basis across the country. Literature suggests problems and abuses have arisen in other states with hospice organizations because of managed care. As managed care comes to Alaska, it may be possible to avoid some of those problems with hospice licensure requirements.

The Health Care Financing Administration (HCFA), who has contracted with the Department to provide oversight of the Medicare certified programs, has for several years limited the on-site survey of these providers to 10% - 15% annually. The result of this HCFA decision is that only one of the three current hospice providers will be surveyed each year. Given the apparent need of Alaskans for this service, as shown by the recent additions of both certified and volunteer hospice providers, it is the opinion of the Department that surveying or inspecting one provider a year does not provide adequate oversight of current hospice programs. In addition, there is every indication we will continue to see a growth of this provider type in the State. Under a licensure program mandated by this Bill, with the amendments below, more frequent on-sight surveys or inspections could be done, and as a result, would help to ensure high quality services are being provided. The fiscal impact would be minimal.

Attached are the recommended changes to SB 96 with the rationale for the those recommendations. We formulated these recommendations based on our own experience with inspecting hospice programs, and following our discussions with Paula McCarron, Hospice of Anchorage, and Richie Sonner, Hospice and Home Care of Juneau. Many of their suggestions and concerns were addressed in our revisions, and they offered their support for the changes.

We appreciate the opportunity to comment on this Bill, and look forward to additional questions or comments you may have.

Sincerely,

Karen Perdue, Commissioner
Department of Health & Social Services

ATTACHMENT

RECOMMENDED CHANGES
SB 96

Chapter 18. Hospice Care Programs
Article 1. Licensing of Hospice Programs.

Article 1. Sec. 18.18.01. Page 1 Lines 6-9. It is recommended that Sec. 18.18.010 be amended to read:

Sec. 18.18.010. **License required.** A person, including a partnership, association, or corporation, may not represent itself as a hospice program, or operate a hospice program, [OR OTHERWISE PROVIDE HOSPICE SERVICES] unless the person, partnership, association, or corporation has obtained a license from the department.

Rationale: *Because the definition of "hospice services" is so broad, the language "otherwise provide hospice services" would restrict or otherwise require licensure for volunteer agencies who currently provide supportive services to individuals with terminal disease such as AIDS. In our discussion with hospice representatives their intent was to ensure licensure for anyone representing themselves as a hospice provider.*

Article 1. Sec. 18.18.020. Page 1 Line 10. It is recommended the language in this section be deleted and language adopted to read:

Sec. 18.18.020. **Issuance and renewal of license.** (a) Upon receipt of an application for license and the license fee if required, the department shall issue a license if the applicant meets the requirements established under AS 18.18.010 - 18.18.390. If the applicant does not meet the requirements established under AS 18.18.010 - 18.18.390, but makes continued efforts to comply with them, the department may grant a temporary or provisional license for a reasonable period of time.

(b) Each license issued is for the person, agency, corporation, partnership, association, or other form of organization named on the application and is not transferable or assignable except with the written approval of the department.

(c) The department will establish the standards for license renewal and will determine the renewal period by regulation.

(d) A license is not renewable if it has been suspended or revoked under AS 18.18.030.

Rationale: *The language above represents a clearer statement as to the Department's authority and obligation. Additionally, under this language the department has the ability through regulation to stipulate the survey and license cycle which may be one year or could be determined by history of compliance and other indicators.*

Article 1. Sec. 18.18.030. Page 2 Line 6. It is recommended the language in this section be deleted and language adopted to read

Sec. 18.18.030. **Denial, Suspension, or revocation of license.** (a) The department will, in its discretion, deny, reduce to a provisional license, or revoke a hospice agency application or license if the department finds that the agency:

(1) has endangered the health, safety, or welfare of a client;

(2) has a history of deficiencies in quality of care;

(3) has had a license to operate a hospice agency revoked in any licensing jurisdiction;

(4) has been convicted of operating a hospice agency without a license in any licensing jurisdiction;

(5) lacks a sufficient number of personnel who have the training, experience, or judgment to provide adequate hospice care;

(6) has committed fraud, deceit, misrepresentation, or dishonesty associated with the application for or operation of a hospice agency in any licensing jurisdiction; or

(7) has violated regulations adopted under this chapter.

(b) The department will, in its discretion, and without a hearing, summarily suspend a hospice agency license if it finds that the actions or deficiencies of the agency cause an immediate and serious threat to the public health, safety, or welfare. A summary suspension remains in effect until such time as the department finds that the actions or deficiencies are corrected or the license is revoked.

(c) The department will, in its discretion, and without a hearing, reduce a hospice agency license to a provisional license for a period of time established by the department, if the department finds that an agency is temporarily unable to comply with the provision of this chapter, or is in the Medicare decertification process, but is taking the appropriate steps necessary to bring the agency into compliance. An agency holding a provisional license may not accept new patients. If the agency fails to correct its deficiencies within the provisional license period, the department will revoke that agency's license.

(d) Application denial, and revocation actions by the department shall be conducted under AS 44.62 (Administrative Procedures Act).

Rationale: *No other provider type which is licensed and Medicare certified receives deemed status for licensure based on certification compliance. Often state licensure requirements cover areas not regulated by Medicare. State requirements under regulation for licensure of hospice providers would not just mirror federal requirements. Therefore, it is not in the best interest of the public to mandate deemed status.*

The language recommended to replace this Sec. is to provide further clarification and authority felt necessary to enable the Department to carry out its obligation to ensure quality care is provided.

Article 1. Sec. 18.18.040. Page 2 Lines 10-18. It is recommended that Sec. 18.18.040 be amended to read:

Sec. 18.18.040. **Right of entry and inspection.** A duly designated employee of the department may enter the premises of a hospice provider who has applied for a license or who is licensed under this chapter. These employees may inspect [RELEVANT DOCUMENTS OF THE HOSPICE PROVIDER] any and all documents necessary to determine whether the provider is in compliance with this chapter and regulations adopted under this chapter. The right of entry and inspection extends to premises and documents of providers whom the department has reason to believe are providing hospice services without a license. [THESE ENTRIES OR INSPECTIONS MUST BE MADE WITH THE PERMISSION OF THE OWNER OR PERSON IN CHARGE UNLESS A WARRANT IS FIRST OBTAINED.]

Rationale: *Language such as "relevant" is subjective and lends to interpretation. The last sentence is unnecessary.*

Article 1. Sec. 18.18.100. (c). Page 2 Lines 25-26. It is recommended that Sec. 18.18.100. (c) be amended to read.

Sec. 18.18.100. **Requirements for licensure. (c)** A hospice program shall [BE A DISCRETE ENTITY WITH] have at least the following features:

Rationale: *The term "discrete entity" implies a hospice organization would have to be a stand alone organization. Currently one home health agency also provides volunteer hospice services, and one hospital has under it's umbrella a certified hospice agency. This language would introduce confusion and could severely limit organizations which provide other services from obtaining licensing for hospice care. Across the country a significant percentage of community health care agencies have both a certified hospice and home health program component. These agencies commonly utilize many of the same "cross-trained" staff in both programs. However, these programs are not identical in focus, scope and regulatory practice. Therefore, we suggest this language be replaced with "have" to eliminate this concern.*

Article 1. Sec. 18.18.100. (e). Page 3 Lines 6-14. It is recommended that Sec. 18.18.100. (e) be amended to read.

Sec. 18.18.100. **Requirements for licensure. (e)** Hospice services shall be delivered in accordance with a care plan approved by the interdisciplinary team regardless of whether the hospice services are provided by hospice program staff or by contractors. [THE CARE PLAN MUST PROVIDE FOR 24-HOURS-A-DAY, SEVEN-DAYS-A-WEEK SERVICES.] The care plan must be reviewed periodically by the interdisciplinary team and revised as needed. The client, and the client's family if the client desires, must be given the opportunity to participate in the development of the care plan and must be informed of the opportunity to attend interdisciplinary team meetings. The interdisciplinary team must consider the need for at least the following services when developing the care plan:

Rationale: *It is felt the appropriate place to require 24-hour-a-day, seven-days-a-week services is in 18.18.100(f)(3). [See Below] It is the responsibility of the hospice organization to ensure services are available and the care plans should reflect the needs of each client.*

Article 1. Sec. 18.18.100. (f). Page 3 Lines 23-Page 4 Line 1. It is recommended that Sec. 18.18.100. (f) be amended to read.

Sec. 18.18.100. Requirements for licensure. (f) Nursing services provided by a hospice program shall be provided in accordance with a care plan and must be under the direction and supervision of a nurse supervisor. The nurse supervisor shall

(1) develop nursing objectives, policies, and procedures consistent with hospice philosophy;
(2) develop job descriptions for nursing personnel consistent with hospice philosophy;
(3) establish staffing and on-call schedules for nursing staff to ensure 24-hour-a-day, seven-days-a-week services are available; and
(4) develop and implement orientation and training programs for nursing staff.

Rationale: *See above.*

Article 1. Sec. 18.18.100. (j)(1). Page 5 Line 4-7. It is recommended that Sec. 18.18.100. (j)(1) be amended to read:

Sec. 18.18.100. Requirements for licensure. (j). A hospice program shall maintain, at a minimum, the following records:

(1) a [MEDICAL] record for each client that includes copies of the client's care plan, progress notes, assessments, and a description of services provided to the client and the client's family;

Rationale: *After consultation with providers both certified and volunteer hospice programs, it was determined the term "medical" in reference to records would not apply to all hospice providers since volunteer organizations may not be following a medical model.*

Article 1. Sec. 18.18.100. (n). Page 5 Lines 23-25. It is recommended that Sec. 18.18.100. (n) be deleted.

Rationale: *The intent of (n) was that if hospice programs that provided 24 hour inpatient/residential hospice services be Medicare certified prior to licensure. It is not appropriate to require certification prior to licensure. In order to meet the requirements of 18.18.010, a license would have to be obtained prior to certification. It is generally required that most provider types be in business for 30 to 45 days and have client records available for review before certification compliance can be adequately assessed. Any person or entity operating a 24 hour inpatient/residential hospice program would need to meet the requirements of this legislation.*

Article 2. Licensing of Volunteer Hospice Programs.

Article 2. Sec. 18.18.200. (a). Page 5 Lines 27-29. It is recommended that Sec. 18.18.200. (a) be amended to read.

Sec. 18.18.200. Licensing requirements. (a) A volunteer hospice program must comply with this section and with [OTHER PROVISIONS OF THIS CHAPTER THAT ARE RELEVANT TO A VOLUNTEER HOSPICE PROGRAM] AS 18.18.010 - AS 18.18.040, AS 18.18.100(a)-(b), As 18.18.100(c)(1)-(3) and (5), AS 18.18.100(d), AS 18.18.100(g), and AS 18.18.100(j)-(l).

Rationale: *This section refers to provisions in the chapter that are relevant to a volunteer hospice program, but does not stipulate which sections are relevant. It is necessary to include all that applies in section 18.18.100 in section 18.18.200. This language would delineate what seems to be appropriate*

requirements of 18.18.101 through 18.18.100 for volunteer hospice agencies. This change has been discussed with providers of both certified and volunteer hospice programs and it was agreeable.

Article 2. Sec. 18.18.200. (b). Page 5 Lines 30 - Page 6 line 7. It is recommended that Sec. 18.18.200. (b) be amended to read.

Sec. 18.18.200. Licensing requirements. (b) At a minimum, a direct service volunteer must

(1) submit a written application;

(2) undergo a screening interview and a [POSTTRAINING] post-training interview;

(3) attend a [20] 18 hour standard training program;

(4) submit a confidentiality statement in which the volunteer agrees to follow the program's policy regarding confidentiality required by AS 18.18.100(k) [AND (a) OF THIS SECTION]; and

(5) if the volunteer will transport individuals, have proof of auto insurance and a valid driver's license.

Rationale: *This change would require the same initial training requirements for volunteer hospice organizations as is required for others. In 18.18.200(4), there is no confidentiality requirement in 18.18.100(a).*

Article 2. Sec. 18.18.200. (c)(7). Page 6 Lines 16. It is recommended that Sec. 18.18.200. (c)(7) be amended to read.

Sec. 18.18.200. Licensing requirements. (c)(7) [INTERDISCIPLINARY] team conferencing;

Rationale: *Interdisciplinary team is defined for organizations licensed under 18.18.100 and includes participation of specified professionals who may not always be available or represented in volunteer organizations.*

Article 2. Sec. 18.18.200. (d). Page 6 Lines 19-25. It is recommended that Sec. 18.18.200. (d) be amended to read.

Sec. 18.18.200. Licensing requirements. (d) Volunteer services in a volunteer hospice must be directed by a coordinator of volunteer services who shall

(1) implement a direct service volunteer program;

(2) coordinate the orientation, education, support, and supervision of direct service volunteers; and

(3) Coordinate the use of direct service volunteers with other hospice staff and community resources.

Article 2. Sec. 18.18.200(e). Page 6 Line 26-27. It is recommended the language in this section be deleted.

Rationale: *All volunteers in a volunteer hospice program should not be required full knowledge of community resources. It is reasonable for the coordinator to have that knowledge in a volunteer hospice agency.*

Article 3. General Provisions.

Article 3. Sec. 18.18.390(11). Page 8 Lines 7-8. It is recommended that Sec. 18.18.390(11) be amended to read.

Sec. 18.18.390. Definitions. (11) "interdisciplinary team," for a hospice providing comprehensive services, means a group comprised of at least a medical director, a licensed nurse, a licensed social worker, a pastoral or other counselor, and a volunteer coordinator or representative; [FOR A VOLUNTEER HOSPICE PROGRAM, "INTERDISCIPLINARY TEAM" MEANS A REGULARLY SCHEDULED CASE CONFERENCE AS DEFINED BY PROGRAM POLICY;]

Rationale: *We took out the requirement for volunteer organizations to have interdisciplinary teams.*

3200 Hospital Dr. Suite 100 ♥ Juneau, Alaska 99801
(907) 463-3113 ♥ FAX 463-3835

March 24, 1997

Hon. Gary Wilken, Chair
Senate HESS
Room #510
State Capitol, Juneau, AK 99801-1182

Dear Senator Wilken:

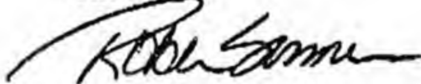
I am writing this letter in support of Senate Bill 96. The following is a brief elaboration of the reasons why I believe it is important for the bill to pass, and remain intact.

The intent of the bill is to prevent just anyone from hanging out a shingle and claiming to provide hospice services. The terminally ill and their families are a vulnerable population, bearing the emotional and physical burden of facing death. While these people are frequently overwhelmed with their situation, it is an unfortunate reality that there is potential opportunity for companies to make money, and provide less than acceptable services. This bill will help to maintain the integrity and the quality of services provided by hospices through the licensing process.

The bill is well written, and adequately differentiates between voluntary hospices and certified hospices. As the administrator of a voluntary hospice, I do not believe that the bill is too restrictive, or puts too much administrative or financial burden on voluntary hospices. I believe that these are *minimum* standards which every agency calling themselves a hospice is ethically obligated to meet to ensure quality of care for its clients.

I encourage you to pass the bill, as it is written, in order for all terminally ill persons in Alaska to be guaranteed high quality hospice care.

Sincerely,



Ritchie Sonner
Executive Director

NHO MEMBER

HOSPICE
& HOME CARE
of Juneau

3200 Hospital Dr. Suite 100 ♥ Juneau, Alaska 99801
(907) 463-3113 ♥ FAX 463-3835

April 8, 1997

Hon. Gary Wilken, Chair
Senate HESS
Room #510
State Capitol
Juneau, Alaska 99801-1182

Dear Senator Wilken:

Thank you for the opportunity to voice my testimony regarding Senate Bill #96.

At the hearing there was discussion regarding a possible amendment to delete voluntary hospices from the bill. This letter is to *urge you to either pass the bill as it is written, or not pass the bill at all*. If we exclude voluntary hospices from the statutes, it would prevent any voluntary hospice from calling themselves a "hospice" or claiming they provide "hospice services". I do not believe this is the intent of the legislation.

I encourage you to think carefully while considering such an amendment. While I support the bill as it is written, I strongly feel that an amendment could do more damage than it could good.

Sincerely,

Ritchie Sonner
Executive Director

Alaska State Legislature

Please enter into the record my testimony to the Senate Bill 96 HESS Finance (committee name) committee on Hospice - Licensing bill/subject, dated ______.

Ketchikan Hospice Support Group has formed a partnership with the KGH - Home Health Department. Ketchikan Hospice Support Group is a volunteer organization that meets the proposed standards. We support this pro-active bill if we may continue in our innovative, flexible, and creative methods for providing Hospice Service in Ketchikan. All Hospices should be following the National Hospice Organization Standards. These Standards are well defined and must be adhered to. We feel strongly about maintaining these standards and feel all Hospices must follow these standards to maintain the integrity of Hospice. If State Regulations are needed to maintain the integrity of Hospice then so be it.

Signed: Dona Fairbanks Phone: 225-8914
Testifier
Ketchikan Hospice Support Group
Representing (Optional)
PO Box 1923 Ketchikan AK 99901
Address

Fax transmitted from Ketchikan Legislative Information Office
Phone: 225-9675 Fax: 225-8546

ALASKA NURSES ASSOCIATION

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(907) 274-0827 FAX: (907) 272-0292

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MAR 24 1997

Testimony of Patricia Senner RN
Alaska Nurses Association
on CS SB 96
March 21, 1997

My name is Patricia Senner, I am a Registered Nurse and Executive Director of the Alaska Nurses Association. The Alaska Nurses Association is testifying today in favor of CS SB 96.

The national debate over the care provided to persons nearing the end of their life has highlighted the need for quality hospice services. We feel the CS SB 96 will help Alaska develop the types of quality services Alaskans need at this time in their lives.

The Nurses Association likes the two-tiered approach to licensing presented in this bill. It sets up a very minimal standard for volunteer hospices, while having broader standards for those hospices who are receiving reimbursement for their services. Setting a minimal standard for volunteer hospices prevents them from being regulated out of existence, and at the same time provides a means for the public to take action against unscrupulous providers. The bill should help hospices receive reimbursement from third party payers since licensing is often a requirement of large national insurance companies.

The Alaska Nurses Association is especially pleased with the emphasis placed in the bill on the role played by the Registered Nurse. About a year ago my brother-in-law died of cancer. He received hospice services, which the family found invaluable. I overheard my sister-in-law say to a friend that you can tell when a person is near the end of their life because the doctor turns over their care to the nurses. Nurses have long been the health care professionals most responsible for caring and supporting patients and their families during the final stage of their lives.

We are pleased that the description of "primary health care provider" includes both physicians and advanced nurse practitioners. Advanced nurse practitioners in Alaska may practice independently and may be the primary care provider for an individual. In that capacity the need might arise for the nurse practitioner to refer patients for hospice services.

In closing I would like to say that the Alaska Nurses Association is in complete agreement with the "hospice philosophy" outlined in the bill. If we deliver services based on this philosophy it will greatly improve the experiences of dying individuals and their families during this difficult transition.

FAX TRANSMITTAL

To: Senate HESS Committee

FAX Phone #: 907-465-4714

Contact Phone # ____________

From: Patricia Senner, RN

FAX Phone #: (907) 272-0292

Contact Phone # (907) 274-0827

Date: 03-24-97

Pages (Including this page): 2

Time: ____________

Comments: Testimony on CS SB 96

In recent years, health care costs and consumers' demand for a broader range of health care options has resulted in the development of more cost-effective outpatient services. This development has included expansion of home health agencies. Home care agencies of various types have been providing in-home services for over a century. However, Medicare's enactment in 1965 made home health services, primarily skilled nursing and therapy of a curative or restorative nature, available to the elderly and, beginning in 1973, to certain disabled younger Americans. In 1965 home health agencies numbered 1,110; in 1994 there were over 7,500; and today there are 10,014 Medicare-approved home health agencies.

Over the past three years in Alaska, home health agencies have grown by more then 100% from 12 to 26, and have been the single fastest growing health care provider type in the state. During 1996, 21 home health agencies in Alaska provided care to over 3,300 patients. Home health agencies currently serve the communities of Anchorage, Fairbanks, Cordova, Juneau, Palmer, Ketchikan, Kodiak, Petersburg, Sitka, Homer, Valdez, Wasilla, Dillingham, Soldotna, Wrangell, Haines, Delta Junction and surrounding areas.

Home health services are those skilled therapeutic services provided to individuals and families in their home or place of residence for the purpose of helping them attain and maintain their highest possible functional capacity, given the constraints of their illness(es). Patients who qualify for home health services must be homebound, need intermittent skilled care, and services that are medically necessary and ordered by a physician.

The quality of services provided by a home health agency are measured by the medical, nursing, and rehabilitative care that the agency organizes, implements, and evaluates as ordered by the physician in the plan of care. Home health agencies must provide skilled nursing and at least one other service. Most home health agencies provide a range of therapeutic services such as physical, occupational and speech therapies, home health aide services, and medical social services. Some programs provide mental health services or other ancillary health services, such as pharmacy or nutritional counseling, even though the latter two services are not reimbursed by Medicare or most other third party payers. Most home health agencies provide medical supplies that are needed to effectively carry out physician orders. Some programs also provide durable medical equipment such as canes, crutches, wheelchairs, etc..

The most important tool the state has for ensuring the quality of home health care is the survey. Surveys, conducted by Division of Medical Assistance Licensing and Certification staff, are used to ensure that agencies comply both with federal requirements for Medicare certification and state licensing requirements. A standardized Functional Assessment Instrument is used for all home health agency surveys to provide an accurate summary of how individuals' medical, nursing and rehabilitative needs are effected by the home health agency services planned, organized, provided, and evaluated in accordance with the physician's plan of care.

Due to the progressive nature of the home health agency industry, and the increasing acuity of home health clients, additional services are being included in everyday home health care that have not yet been covered in the Medicare standards. For those reasons, areas that were

From Health + Social Services

developed in the licensure requirements to ensure the quality of care in the home include the following.

1. Quality Improvement: A home health agency must have a quality improvement program to assess the extent to which the agency's program is appropriate, effective , and efficient.

2. Therapy Services: In Alaska, therapists are allowed to obtain their own patients without a physician's order. To maintain continuity among home health agency services, therapy services offered by a licensed home health agency must be provided in accordance with a plan of care by or under the supervision of a therapist licensed under AS 08.84 Additionally, the therapist's treatment plan must be established or modified upon written or verbal orders from a physician.

3. Nutritional Services: If a plan of care requires the consultation or direct services of a dietitian, a licensed home health agency must ensure that those services are provided by a dietitian registered by the Commission on Dietetic Registration of the American dietetic Association. Additionally, a dietitian must maintain liaison with the physician and agency staff to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.

4. Central Supply: A home health agency shall maintain a separate area for processing, decontamination, if necessary, and storage of sterile supplies and materials.

5. Infusion Services: Home health patients are commonly treated in their homes with intravenous infusions. If a home health agency provides parenteral or hyperalimentation services, the agency shall describe the scope of the services to be provided, develop a plan for emergency services to meet the scope of the services provided, and administer treatments only upon the order of a physician.

6. Advance Directives: Before initiating care or services, a home health agency must provide each patient, 18 years of age or older, or their legal representatives, with forms and information on the right of the individual to make health care decisions, including the right to accept or refuse medical or surgical treatment and the right to execute an advance directive and power of attorney for health care.

7. Abuse, Neglect & Mistreatment: A home health agency shall develop and implement written policies and procedures that prohibit abuse, neglect, and mistreatment of patients.

8. Contracts: A home health agency's contract with another facility or agent to provide home health care or services must specify the respective functions and responsibilities of the contractor, require the contractor to conform to all applicable agency policies, including personnel qualifications, specify the contractor's responsibility for participating in developing a plan of care, specify the manner in which the care or services will be controlled, coordinated, and evaluated by the contracting home health agency.

9. Risk Management: A home health agency must have a risk management program that includes a procedure to investigate, analyze, and respond to patient grievances related to patient

care. Additionally, conduct in each service area, an orientation program for each new employee and annual inservice training.

10. Infection Control: A home health agency shall develop and implement written policies and procedures applicable to all agency staff that minimize the risk of transmitting infection in all patient care or services, provide for the safe handling and disposal of biohazardous and infections materials, verify at least every 2 years that its employees, contractors, and volunteers who provide patient care, receive training on universal precautions and the prevention transmission, and treatment of HIV, AIDS, hepatitis, and tuberculosis.

11. Employee Health Program: A home health agency shall have an employee health program that requires each employee to be tested for pulmonary tuberculosis within the first two weeks of initial employment and annually thereafter. Contractors performing patient care or services for the agency must have similar standards in place. Each employee who provides direct patient care to pregnant women shall be immunized against rubella.