**Section 280.2080 Hospice Program Care**

a) *The hospice program shall coordinate its services with professional and nonprofessional services already in the community.* (Section 8(b) of the Act)

b) *The* hospice *program may contract out for elements of its services.* (Section 8(b) of the Act) If services are contracted, the hospice care team is responsible for maintaining direct patient contact and overall coordination of hospice services.

c) *Any contract entered into between a hospice and a health care facility or service provider shall specify that the hospice care team retains the responsibility for planning and coordinating hospice services and care on behalf of a hospice patient and his*/her *family.* (Section 8(b) of the Act)*.*

d) *All contracts shall be in compliance with* the *Act.*

e) *No hospice* that *contracts for any hospice services shall charge fees for services provided directly by the hospice care team* that *duplicate contractual services provided to the individual patient or his*/her *family.* (Section 8(b) of the Act)

f) *The hospice program must fully disclose in writing to any hospice patient, or to any hospice patient's family or representative, prior to the patient's admission, the hospice services available from the hospice program and the hospice services for which the hospice patient may be eligible under the patient's third-party payer plan (that is, Medicare, Medicaid, the Veterans Administration, private insurance or other plans).* (Section 8(a-10) of the Act)

g) Each hospice program shall develop written policies and procedures for admissions and discharges, the function of the hospice care team, and the development of the patient care plan.

1) Admissions to the hospice program shall be limited to interested individuals who have been determined by their attending physician as having a terminal illness for which palliative care is considered the appropriate medical regimen.

2) Restrictions by geographic areas must be clearly stated by each hospice program.

3) Upon admission, the hospice care team shall coordinate an evaluation of the patient's physical, medical, spiritual, social and psychological needs. The patient and the hospice patient's family shall be evaluated to determine the unit of care.

4) Hospice services are voluntary and may be refused or stopped in accordance with written policies and procedures. The patient may request a return to curative treatment, at which time the need for hospice services is to be re-evaluated.

h) Function of the Hospice Care Team

1) Each comprehensive hospice will have, at a minimum, an interdisciplinary working unit called the hospice care team. This unit shall be composed of, at a minimum, the attending physician, a nurse, a social worker, a counselor, and trained volunteers. The patient, patient's physician and patient's family are considered members of the hospice care team when development or revision of the patient's plan of care takes place.

2) Each volunteer hospice shall have a hospice care team consisting of staff from each of the services provided. The patient, patient's attending physician and patient's family are considered members of the hospice care team when development or revision of the patient's plan of care takes place. The hospice care team must participate in the development of every patient care plan. The hospice care team must establish a procedure to review each patient care plan on an ongoing basis, but at least monthly.

i) Patient Care Plan

1) Each comprehensive and volunteer hospice shall ensure that there is a written plan of care for each patient. The hospice care team will complete an assessment of the care needs and evaluate the ability of the patient to be cared for in his/her place of residence.

2) The plan shall be updated based on ongoing assessments by the hospice care team.

3) The patient care plan shall provide for involvement of the family in treatment.

4) Each comprehensive hospice or volunteer hospice providing services to a patient in both the home setting and the inpatient setting must have written policies and procedures to share the written plan of care between both settings to facilitate continuity of care.

(Source: Amended at 32 Ill. Reg. 2330, effective January 23, 2008)