

# Visitation Standards: Meeting CMS Hospital CoPs and Federal Law



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# Objectives

- Explain why hospital staff must be educated on the visitation interpretive guidelines.
- Describe the federal regulation on visitation that affects all hospitals receiving Medicare reimbursement.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

# Visitation Law in a Nutshell



- Require all hospitals that accept Medicare or Medicaid reimbursement
- To allow adult patients to designate visitors
- Not legally related by marriage or blood to the patient
- To be given the same visitation privileges as an immediate family member of the patient

## Hospital changes policy after refusing to let lesbian to visit her dying partner

SDGLN Staff | Mon, 04/12/2010 - 11:48am | [Login to bookmark or comment](#)

MIAMI – Jackson Memorial Hospital may be ranked among “America’s Best Hospitals,” but it has a spotty track record in dealing with LGBT issues.

While a lesbian was dying in the hospital, hospital officials denied her partner visitation rights. The decision drew rebuke from gay rights advocates and others concerned about the hospital’s visitation policy.

Today, Lambda Legal, its coalition partners, and officials from Jackson Health System (JHS) released a statement announcing the hospital’s improved policies that are more responsive to the needs of the LGBT community. Lambda Legal noted that the new policies still do not provide as much protection as may be needed in critical situations.

Lambda Legal urged Jackson Memorial Hospital to enact a full grievance procedure and also to issue an apology to the Langbehn-Pond family.

“Lambda Legal applauds Jackson Memorial’s work with the coalition to review and expand policies and training materials to help address the needs of same-sex couples and their families, but we urge the hospital to finish the job,” said Beth Littrell, senior staff attorney in Lambda Legal’s Southern Regional Office in Atlanta, who was lead counsel on *Langbehn v. Jackson Memorial*.

“The hospital should issue an official apology to the Langbehn-Pond family and JHS should have a grievance procedure in the case of visitation denial that can be acted on quickly in an emergency situation,” she said.

“Jackson Memorial Hospital should have been able to provide immediate resources to Janice Langbehn when she wasn’t allowed to be with her partner Lisa hour after hour as she lay dying in the hospital. We don’t want the Langbehn-Pond nightmare to happen to another family.”

Last September, the court rejected Lambda Legal’s lawsuit filed against Jackson Memorial Hospital on behalf of Janice Langbehn, ruling that no law required the hospital to allow her and their three children to see her partner, Lisa Pond. Langbehn and the children were kept apart from Pond by hospital staff for eight hours as Pond slipped into a coma and died.



Hospitals and medical centers nationwide are changing their visitation policies in response to the needs of culturally diverse clientele, competition from other hospitals and new thought on the advantages of families at the bedside.

# Visitation Rights The Law and IGs

- First, there is a federal regulation on visitation that went into effect January 18, 2011
- Second, CMS issues a **34 page memo** implementing interpretive guidelines for hospitals including critical access hospitals
  - These went beyond just visitation
  - These amended consent, advance directives, plan of care, and other important sections of the hospital CoP
  - Issued September 7, 2011 and Transmittal issued December 2, 2011 and now in current CMS CoP manual and hospitals still struggling to comply

# Location of CMS Hospital CoP Manual

## Medicare State Operations Manual Appendix

Email questions [hospitalscg@cms.hhs.gov](mailto:hospitalscg@cms.hhs.gov)

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers

CMS CoP Manuals are now located at

[www.cms.hhs.gov/manuals/downloads/som107\\_Appendixtoc.pdf](http://www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf)

App. No.	Description	PDF File
A	Hospitals	 <a href="#">2,185 KB</a>
AA	Psychiatric Hospitals	 <a href="#">606 KB</a>

# CoP Manual Also Called SOM

## **State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals**

**Table of Contents**  
*(Rev. 151, 11-20-15)*

[www.cms.hhs.gov/manuals/downloads/som107Appendixtoc.p](http://www.cms.hhs.gov/manuals/downloads/som107Appendixtoc.p)

### [Transmittals for Appendix A](#)

### Survey Protocol

#### Introduction

Task 1 - Off-Site Survey Preparation

Task 2 - Entrance Activities

Task 3 - Information Gathering/Investigation

Task 4 - Preliminary Decision Making and Analysis of Findings

Task 5 - Exit Conference

Task 6 - Post-Survey Activities

Psychiatric Hospital Survey Module

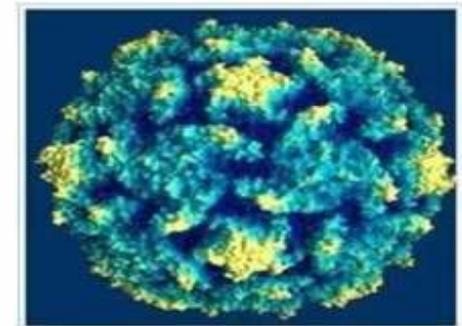
Psychiatric Unit Survey Module

Rehabilitation Hospital Survey Module

Inpatient Rehabilitation Unit Survey Module

Hospital Swing-Bed Survey Module

Email questions  
[hospitalscg@cms.hhs.gov](mailto:hospitalscg@cms.hhs.gov)



**Regulations and Interpretive Guidelines**

# Visitation Memo

- Make sure your policies and procedures include the information in the visitation memo
  - Since amends **8 sections** of the hospital CoP manual use the survey memo or transmittal to go through each section to include all information is included in your policy
  - Hospitals are still struggling with compliance
- Make sure all staff are educated on your visitation policy
  - Include in orientation
  - Train existing staff
  - Don't forget to educate your physicians and licensed independent practitioners (LIPs)

# Transmittals

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[www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2016-Transmittals.html](http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2016-Transmittals.html)

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<a href="#">SE1606</a>		Guidance on the Physician Quality Reporting System (PQRS) 2014 Reporting Year and 2016 Payment Adjustment for Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Critical Access Hospitals (CAHs)			SE1606
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Provider Enrollment Revolidation

# CMS Survey and Certification Website

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## Survey & Certification - General Information

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- » Spotlight
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- » Contact Information
- » CMS National Background Check Program
- » Nursing Home Quality Assurance & Performance Improvement Initiative
- » Revisit User Fee Program
- » Accreditation
- » **Policy & Memos to States and Regions**

## Policy & Memos to States and Regions



CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

### Select From The Following Options:

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**Click on Policy & Memos**

# CMS Survey Memos

## Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

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<a href="#">Certification Number (CCN) State Codes –State Operations Manual (SOM) Section 2779A Revisions</a>	16-09-ALL	2016-03-11	2016
<a href="#">Advance Copy – Interpretive Guidelines for the Organ Transplant Conditions of Participation (CoPs) at 42 Code of Federal Regulations (CFR) §§ 482.68 through 482.104</a>	16-10-Transplant	2016-03-11	2016
<a href="#">National Downtime of the Quality Improvement and Evaluation System (QIES)</a>	16-12-ALL	2016-03-11	2016
<a href="#">Critical Access Hospital (CAH) Recertification Checklist for Evaluation of Compliance with the Location and Distance Requirements</a>	16-08-CAH	2016-02-12	2016
<a href="#">FY 2015 Report to Congress (RTC): Review of Medicare’s Program Oversight of Accrediting Organizations (AOs) and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) Validation Program</a>	16-07-AO	2016-01-29	2016
<a href="#">Medicare Learning Network (MLN) Infection Control Courses</a>	16-06-ALL	2016-01-22	2016

# Spouse Includes Same Sex Marriages

- CMS publishes 6 pages in December 14, 2014 Federal Register
- CMS issues ten page survey memo December 12, 2014
- CMS amends manual October 9, 2015 to include this
- Recognizes the rights of a spouse in legally valid same sex marriages
- Equal rights to the spouse and treated the same as opposite-sex marriages
- Must honor regardless of where the couple resides

# Spouse Includes Same Sex Marriages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop C2-21-16  
Baltimore, Maryland 21244-1850



Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 15-13-ALL

**DATE:** December 12, 2014

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Clarification of Terms Implicating the Spousal Relationship in Regulations and Guidance for Medicare- and Medicaid-certified Providers and Suppliers.

## Memorandum Summary

- *Clarification of "Spouse" & Related Terms:* The Centers for Medicare and Medicaid Services (CMS) is clarifying that the terms "spouse", "marriage," "relative," and "family," as well as other terms that implicitly or explicitly implicate the spousal relationship, such as (but not limited to) "representative," "support person," "surrogate," and "next-of-kin," include all marriages lawful where entered into, including lawful same-sex marriages, regardless of the certified provider's or supplier's location or the jurisdiction in which the spouse lives.

# FR Rights Spouse of Same Sex Marriages

GPO

Federal Register / Vol. 79, No. 239 / Friday, December 12, 2014 / Proposed Rules

73873

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

42 CFR Part 416, 418, 482, 483, and 485  
[CMS-3302-P]

RIN 0938-AS29

### Medicare and Medicaid Program; Revisions to Certain Patient's Rights Conditions of Participation and Conditions for Coverage

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Proposed rule.

**SUMMARY:** This proposed rule would revise the applicable conditions of participation (CoPs) for providers, conditions for coverage (CfCs) for suppliers, and requirements for long-term care facilities, to ensure that certain requirements are consistent with the Supreme Court decision in *United States v. Windsor*, 570 U.S.12, 133 S.Ct. 2675 (2013), and HHS policy. Specifically, we propose to revise certain definitions and patient's rights provisions, in order to ensure that same-sex spouses in legally-valid marriages are recognized and afforded equal rights

Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments only to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-9994 in

Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

### Table of Contents

This proposed rule is organized as follows:

- I. Background
    - A. *United States v. Windsor* Decision
    - B. Statutory and Regulatory Authority
  - II. Provisions of the Proposed Regulation
    - A. Ambulatory Surgical Centers Condition for Coverage—Patient Rights (§ 416.50)
    - B. Hospice Care (Part 418)
    - C. Conditions of Participation for Hospitals (Part 482)
    - D. Requirements for States and Long-Term Care (LTC) Facilities (Part 483)
    - E. Conditions of Participation: Community Mental Health Centers (CMHCs) (Part 485, Subpart J)
  - III. Collection of Information Requirements
  - IV. Response to Comments
  - V. Regulatory Impact Statement
- Regulations Text

### I. Background

#### A. *United States v. Windsor* Decision

In *United States v. Windsor*, 570 U.S. 12, 133 S. Ct. 2675 (2013), the Supreme Court held that section 3 of the Defense of Marriage Act (DOMA) is unconstitutional because it violates the Fifth Amendment (*See Windsor*, 133 S.

# CMS Amends Manual 10-9-2015 Spouse

## *Regulations and Interpretive Guidelines*

*(Rev. 149, Issued: 10-09-15, Effective: 10-09-15, Implementation: 10-09-15)*

*NOTE: in the regulations or guidance which follow, in every instance where the following terms appear:*

- *“spouse” means an individual who is married to another individual as a result of marriage lawful where it was entered into, including a lawful same-sex marriage, regardless of whether the jurisdiction where the hospital is located, or in which the spouse lives, permits such marriages to occur or recognizes such marriages.*
- *“marriage” means a marriage lawful where entered into, including a lawful same-sex marriage, regardless of whether the jurisdiction where the hospital is located, or in which the spouse lives, permits such marriages to occur or recognizes such marriages;*
- *“family” includes, but is not limited to, an individual’s “spouse” (see above); and*
- *“relative” when used as a noun, includes, but is not limited to, an individual’s “spouse” (see above).*

*Furthermore, except where CMS regulations explicitly require an interpretation in accordance with State law, wherever the text of a regulation or associated guidance uses the above terms or includes a reference to a patient’s “representative,” “surrogate,” “support person,” “next of kin,” or similar term in such a manner as*

# Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to [bettercare@cms.hhs.com](mailto:bettercare@cms.hhs.com)
- This is the CMS 2567 deficiency data and lists the tag numbers
- Updated quarterly
  - Available under downloads on the hospital website at [www.cms.gov](http://www.cms.gov)

# Access to Hospital Complaint Data

- There is a list that includes the hospital's name and the different tag numbers that were found to be out of compliance
  - Many on restraints and seclusion, EMTALA, infection control, consent, advance directives and grievances and **patient rights and visitation**
- Two websites by private entities also publish the CMS nursing home survey data and hospitals
- The ProPublica website for LTC
- The Association for Health Care Journalist (AHCJ) websites for hospitals

# Access to Hospital Complaint Data

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
2000 Pennsylvania Boulevard, Mail Stop C3-21-10  
Baltimore, Maryland 21244-1800



Center for Clinical Standards and Quality/Survey & Certification Group

Re: S&C: 13-21- ALL

**DATE:** March 21, 2013  
**TO:** State Survey Agency Directors  
**FROM:** Director  
Survey and Certification Group  
**SUBJECT:** Access to Statements of Deficiencies (CMS-2567) on the Web for Skilled Nursing Facilities, Nursing Facilities, Hospitals, & Critical Access Hospitals

## Memorandum Summary

- **Survey Findings Posted on [www.access.gpo.gov](http://www.access.gpo.gov):** In July 2012, the Centers for Medicare & Medicaid Services (CMS) began posting redacted Statements of Deficiencies (CMS-2567s) for skilled nursing facilities and nursing facilities on *Nursing Home Compare*. In March 2013, CMS began posting CMS-2567s for short-term acute care hospitals and critical access hospitals (CAHs) for surveys based on complaint investigations. This memorandum describes the contents and location of these files.
- **Other Web-based Tools Based on These Data:** At least two additional websites, provided by private parties (*ProPublica* and the Association for Health Care Journalists), publish information based on the CMS-2567 data. These websites are independent of CMS. CMS does not endorse or sponsor any particular private party application.
- **Plans of Correction (POC):** The posted CMS data do not contain any POC information. State Survey Agencies (SAs) and CMS Regional Offices (RO) may see an increase in requests for both the CMS-2567 and any associated POCs.
- **Questions & Answers:** We plan to issue an update to this memorandum that will include an attachment of frequently asked questions in order to provide answers to other queries that may arise.

## Background – Nursing Home Survey Findings

In July 2012, CMS began posting nursing home statements of deficiencies, derived from the Form

# Updated Deficiency Data Reports

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Home > Medicare > Survey & Certification - Certification & Compliance > Hospitals

## Survey & Certification - Certification & Compliance

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## Hospitals

This page provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, regulations, and compliance information.

A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation. The State Survey Agency evaluates and certifies each participating hospital as a whole for compliance with the Medicare requirements and certifies it as a single provider institution.

Under the Medicare provider-based rules it is possible for 'one' hospital to have multiple inpatient campuses and outpatient locations. It is not permissible to certify only part of a participating hospital. Psychiatric hospitals that participate in Medicare as a Distinct Part Psychiatric hospital are not required to participate in their entirety.

However, the following are not considered parts of the hospital and are not to be included in the evaluation of the hospital's compliance:

- Components appropriately certified as other kinds of providers or suppliers. i.e., a distinct part Skilled Nursing Facility and/or distinct part Nursing Facility, Home Health Agency, Rural Health Clinic, or Hospice; Excluded residential, custodial, and non-service units not meeting certain definitions in the Social Security Act; and,
- Physician offices located in space owned by the hospital but not functioning as hospital outpatient services departments

**Accredited Hospitals** - A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital's compliance with the Medicare Conditions of Participation (CoP) for all services, areas and locations covered by the hospital's provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct

[www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals.html)

# Visitation Memo Deficiencies Jan 28, 2016

Name	Tag Number	Number of Deficiencies
Notice of Patient Rights	117	218
Care Planning	130	115
Informed Consent	131	281
Informed Decisions	132	73
Patient Admission Status	133	18
Patient Visitation Rights	215	20
Patient Visitation Rights	216	18
Patient Visitation Rights	217	7
		<b>Total 750</b>

# Deficiencies

- No written visitation P&P
- Failed to follow visitation policy
- Did not assure visitation P&P was clinically necessary
- Failed to address how staff would be trained in visitation P&P
- Interviewed patients and they were not informed about visitation rights
- Failed to give patients a copy of visitation P&P
- Did not outline in P&P about support person
- Did not address same sex partners

# Who is a Patient Representative?

- Parent of a minor child
- Guardian
- DPOA of a patient who is incapacitated
- Support person/visitation advance directive who is also referred to as the patient advocate by the Joint Commission
  - Called care partner by some hospitals
- If patient has no advance directives on file it can be whoever shows up and claims to be the patient representative like the spouse, same sex partner, friend, etc.

# CMS Gives Rights to Support Persons

- Right to be involved in the plan of care
- CMS says patient representative should sign the consent form **even** if the patient is competent
- CMS says the patient advocate or support person is to be given a copy of the patient rights **even** if the patient is competent (not incapacitated)
- CMS says has right to chose who visitors will be if patient is not competent to make the decision
- Suggest a form be signed so patient is aware and to protect HIPAA rights and include all four
- Include in your P&P section on support persons

# TJC Speak Up Patient Advocates

You have rights and a role regarding your treatment and care. This brochure has questions and answers to help you find out about your rights and role as a patient. Knowing your rights and role can help you make better decisions about your care.

## What are your rights?

- You have the right to be informed about the care you will receive.
- You have the right to get information about your care in your language.
- You have the right to make decisions about your care, including refusing care.
- You have the right to know the names of the caregivers who treat you.
- You have the right to safe care.
- You have the right to have your pain treated.
- You have the right to know when something goes wrong with your care.
- You have the right to get an up-to-date list of all of your current medicines.
- You have the right to be listened to.
- You have the right to be treated with courtesy and respect.

Ask for written information about all of your rights as a patient.

## What is your role in your health care?

- You should be active in your health care.
- You should ask questions.
- You should pay attention to the instructions given to you by your caregivers. Follow the instructions.

- You should share as much information as possible about your health with your caregivers. For example, give them an up-to-date list of your medicines. And remind them about your allergies.

## Can your family or friends help with your care?

Find out if there is a form you need to fill out to name your personal representative, also called an advocate. Ask about your state's laws regarding advocates.

## How can an advocate help with your care?

They can get information and ask questions for you when you can't. They can remind you about instructions and help you make decisions. They can find out who to go to if you are not getting the care you need.

## Can your advocate make decisions for you?

No, not unless they are your legal guardian or you have given them that responsibility by signing a legal document, such as a health care power of attorney.

## Can other people find out about your disease or condition?

The law requires health care providers to keep information about your health private. You may need to sign a form if you want your health care providers to share information with your advocate or others.

## What is "informed consent?"

This means that your health care providers have talked to you about your treatment and its risks. They have also talked to you about options to treatment and what can happen if you aren't treated.

[www.jointcommKnow\\_Your\\_Rights/ission.org/Speak\\_Up\\_\\_](http://www.jointcommKnow_Your_Rights/ission.org/Speak_Up__)

# TJC Speak Up Patient Advocate



Ask a trusted family member or friend to be your advocate (advisor or supporter).

- Your advocate can ask questions that you may not think about when you are stressed. Your advocate can also help remember answers to questions you have asked or write down information being discussed.
- Ask this person to stay with you, even overnight, when you are hospitalized. You may be able to rest better. Your advocate can help make sure you get the correct medicines and treatments.
- Your advocate should be someone who can communicate well and work cooperatively with medical staff for your best care.
- Make sure this person understands the kind of care you want and respects your decisions.
- Your advocate should know who your health care proxy decision-maker is; a proxy is a person you choose to sign a legal document so he or she can make decisions about your health care when you are unable to make your own decisions. Your advocate may also be your proxy under these circumstances. They should know this ahead of time.
- Go over the consents for treatment with your advocate and health care proxy, if your proxy is available, before you sign them. Make sure you all understand exactly what you are about to agree to.
- Make sure your advocate understands the type of care you will need when you get home. Your advocate should know what to look for if your condition is getting worse. He or she should also know who to call for help.

[www.jointcommission.org/speak\\_up\\_help\\_prevent\\_errors\\_in\\_your\\_care/](http://www.jointcommission.org/speak_up_help_prevent_errors_in_your_care/)

# Patient Visitation Right

- This rule revises the hospital CoPs to ensure visitation rights of all patients including same sex domestic partners
- Hospitals are required to have policies and procedures (P&P) on this
- P&P must set forth any clinically necessary or reasonable restrictions or limitations
- Hospitals will have to train all staff
- Hospitals will be required to give a written copy of this right to all patients in advance of providing treatment

# Visitation Rights for All Patients

- The law implemented the April 15, 2010 Presidential memo which is what started this change<sup>1</sup>
  - The President gave HHS (Health and Human Services) the task of requiring any hospital that receives Medicare reimbursement to preserve the rights of all patients to choose who can visit them
  - Patients or their representative have a right to visitation privileges that are no more restrictive than those for immediate family members
- 1 <http://www.whitehouse.gov/the-press-office/presidential-memorandum-hospital-visitation>
  - 2 [http://www.access.gpo.gov/su\\_docs/fedreg/a100628c.html](http://www.access.gpo.gov/su_docs/fedreg/a100628c.html) (June 28, 2010 Federal Register)

# Started with a Presidential Memo



The screenshot shows the White House website interface. At the top, there is a navigation bar with the text "the WHITE HOUSE PRESIDENT BARACK OBAMA" and a logo of the White House. Below this, there are links for "BLOG", "PHOTOS & VIDEO", "BRIEFING ROOM", "ISSUES", and "the ADMINISTRATION". A breadcrumb trail reads "Home • Briefing Room • Presidential Actions • Presidential Memoranda". The main content area is titled "The White House Office of the Press Secretary" and contains a memorandum dated "April 15, 2010" for immediate release. The memorandum is titled "Presidential Memorandum - Hospital Visitation" and is addressed to the Secretary of Health and Human Services. The subject is "Respecting the Rights of Hospital Patients to Receive Visitors and to Designate Surrogate Decision Makers for Medical Emergencies". The text of the memorandum discusses the importance of compassion and companionship for patients in hospitals and mentions that many patients are denied this support.

the WHITE HOUSE PRESIDENT BARACK OBAMA

★ ★ ★ ★

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the ADMINISTRATION

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The White House

Office of the Press Secretary

For Immediate Release April 15, 2010

**Presidential Memorandum - Hospital Visitation**

MEMORANDUM FOR THE SECRETARY OF HEALTH AND HUMAN SERVICES

SUBJECT: Respecting the Rights of Hospital Patients to Receive Visitors and to Designate Surrogate Decision Makers for Medical Emergencies

There are few moments in our lives that call for greater compassion and companionship than when a loved one is admitted to the hospital. In these hours of need and moments of pain and anxiety, all of us would hope to have a hand to hold, a shoulder on which to lean -- a loved one to be there for us, as we would be there for them.

Yet every day, all across America, patients are denied the kindnesses and caring of a loved one at their sides -- whether in a sudden medical emergency or a prolonged hospital stay. Often, a widow or widower with no children is denied the support and comfort of a good friend. Members of religious orders are sometimes unable to be

# Visitation Rights for All Patients

- Memo was entitled “Respecting the Rights of Hospital Patients to Receive Visitors and to Designate Surrogate Decision Makers for Medical Emergencies”
- President says there are few moments in our lives that call for greater compassion and companionship that when a loved one is admitted to the hospital
- A widow with no children is denied the support and comfort of a good friend
- Members of religious organizations unable to make medical decisions for them (can do DPOA)

# Visitation Rights for All Patients

- Medical staff may not have best information on H&P and medications if friends or certain family members are unable to serve as intermediaries
- Notes that some states have passed laws on this already such as North Carolina in the Patient's Bill of Rights
  - Gives each patient the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient

# Followed By HHS Memo

## News Release

FOR IMMEDIATE RELEASE  
Wednesday, June 23, 2010

Contact: HHS Press Office  
(202) 690-6343

### **Medicare Proposes New Rules to Ensure Equal Visitation Rights for All Hospital Patients**

#### *Patients to Designate Their Own Visitors, Including Domestic Partners*

The Centers for Medicare & Medicaid Services (CMS) today proposed new rules for hospitals that would protect patients' rights to choose their own visitors during a hospital stay, including visitors who are same-sex domestic partners.

The new proposed rules implement an April 15, 2010, Presidential memorandum, in which the President tasked HHS with developing proposed standards for Medicare- and Medicaid-participating hospitals (including critical access hospitals) that would require them to preserve the rights of all patients to choose who may visit them when they are inpatients of a facility.

The proposed rules would require every hospital to have written policies and procedures detailing patients' visitation rights, as well as instances when the hospital may restrict patient access to visitors based on reasonable clinical needs.

A key provision of the proposed rules specifies that visitors chosen by the patient (or his or her representative) must be able to enjoy visitation privileges that are no more restrictive than those for immediate family members.

"Every patient deserves the basic right to designate whom they wish to see while in the hospital," said HHS Secretary Kathleen Sebelius. "Today's proposed rules would ensure that all patients have equal access to the visitors of their choosing—whether or not those visitors are, or are perceived to be, members of a patient's family."

The proposed rules would update the Conditions of Participation, which are minimum health and safety standards all Medicare- and Medicaid-participating hospitals and critical access hospitals must meet.

Specifically, the proposed rules would add new requirements for hospitals and critical access hospitals to explain to all patients their right to choose who may visit them during their inpatient stay, regardless of whether the visitor is a family member, a

# Visitation Rights for All Patients

- “Every patient deserves the basic right to designate whom they wish to see while in the hospital.”
- “Today’s rules would ensure that all patients have equal access to the visitors of their choosing—whether or not those visitors are, or are perceived to be, members of a patient’s family.” HHS Secretary Kathleen Sebelius.
- Aimed at providing equal rights and privileges from the healthcare system regardless of their personnel and family situation

# Visitation Rights for All Patients

- We knew it would be included in the CAH and PPS hospital CoPs manual
- All hospitals that accept Medicare payments are required to follow the hospital CoPs
- This is a requirement for all patients and not just Medicare patients such as private insurance, no pay, worker compensation patients etc.
- Medicare hospitals (about 98% of hospitals in the US, not VA Hospitals since don't take Medicare)
  - TJC has visitation standard located in patient centered communication

# Visitation Rights for All Patients in a Nutshell

- Hospitals would have to explain to all patients their right to choose who may visit them during their inpatient stay
- Regardless of whether the visitor is a family member, a spouse, or a domestic partner (including a same-sex domestic partner)
- As well as the right to withdraw such consent at any time
- Reasonable or necessary restrictions would be in the P&P

# Visitation Rights Federal Register

- FR discusses the President's memo when the changes were published
  - Some patients are denied most basic of human needs because their loved ones and close friends do not fit the traditional concept of family
- Discusses current requirements of the hospital CoPs and CMS adds 34 page guidelines
- These patient rights are in the PPS hospital CoP under Tags 117, 130, 131, 132, 215-217, & 151
- Included changes to CAH under Tag 1000-1002 which is located behind Tag 298

# CAH Tag 1000 on Visitation Follows 298

## **C-0298**

**485.635(d)(4) A nursing care plan must be developed and kept current for each inpatient.**

### **Interpretive Guidelines §485.635(d)(4)**

Nursing care planning starts upon admission. It includes planning the patient's care while in the CAH as well as planning for discharge to meet post-CAH needs. A nursing care plan is based on assessing the patient's nursing care needs and developing appropriate nursing interventions in response to those needs. The nursing care plan is kept current by ongoing assessments of the patient's needs and the patient's response to interventions, and updating or revising the patient's nursing care plan in response to assessments. The nursing care plan is part of the patient's medical record and must comply with the requirements for patient records.

### **Survey Procedures §485.635(d)(4)**

Select a sample of nursing care plans (6-12 as appropriate)

- Are the plans initiated as soon as possible after admission for each patient?
- Does the plan describe patient goals and appropriate physiological and psychosocial factors and patient discharge planning?
- Is the plan consistent with the attending practitioner's plan for medical care?
- Are the plans revised as the needs of the patient change?
- Are the plans implemented?

## **C-1000**

*(Rev. 75, Issued: 12-02-11, Effective: 12-02-11, Implementation: 12-02-11)*

*§485.635(f) Standard: Patient visitation rights. A CAH must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation...*

# Final Language on Patient Visitation Rights

- Standard: Patient visitation rights
- A hospital must have written P&P regarding the visitation rights of patients
  - This includes setting forth any clinically necessary
  - Or reasonable restriction or limitation that the hospital may need to place on such rights
  - And the reasons for the clinical restriction or limitation

# Final Language on Patient Visitation Rights

- A hospital must meet the following 4 requirements:
  1. Inform each patient (or support person, where appropriate) of his or her visitation rights
    - Including any clinical restriction or limitation on such rights
    - When he or she is informed of his or her other rights under this section (previously mentioned)

# Final Language on Patient Visitation Rights

2. Inform each patient (or support person, where appropriate) of the right
  - Subject to his or her consent
  - To receive the visitors whom he or she designates
  - Including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner),
  - Another family member, or a friend, and his or her right to withdraw or deny such consent at any time

# Final Language on Patient Visitation Rights

- 3. Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability
- 4. Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences
- So what does this mean??
  - Explained in more detail in the 34 pages of Interpretive Guidelines

# Visitation Interpretive Guidelines 117

- CMS published 34 page interpretive guidelines which amended the hospital CoP manual
  - CAH s CoPs have similar language and the exact language and tag numbers are at the end
- Also discusses extending patient rights to patient representatives
- Reiterated many of the patient rights like notice of patient right must be given to the patient and/or their representative
- Need to take reasonable steps to determine patient wishes concerning designation of a representative

# CMS Visitation Transmittal Dec 2 2011

A-0117

[www.cms.gov/Transmittals/01\\_overview.asp](http://www.cms.gov/Transmittals/01_overview.asp)

*(Rev. 75, Issued: 12-02-11, Effective: 12-02-11, Implementation: 12-02-11)*

**§482.13(a)(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.**

## **Interpretive Guidelines §482.13(a)(1)**

The hospital must inform each patient, or when appropriate, the patient's representative as allowed by State law, of the patient's rights. Whenever possible, this notice must be provided before providing or stopping care. All patients, inpatient or outpatient, must be informed of their rights as hospital patients. The patient's rights include all of those discussed in this condition, as well as any other rights for which notice is required under State or Federal law or regulations for hospital patients. (See [42 CFR 482.11](#).) The patient's rights should be provided and explained in a language or manner that the patient (or the patient's representative) can understand. *This is consistent with the guidance related to Title VI of the Civil Rights Act of 1964 issued by the Department of Health and Human Services - "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (August 8, 2003, 68 FR 47311). In accordance with §482.11, hospitals are expected to comply with Title VI and may use this guidance to assist it in ensuring patient's rights information is provided in a language and manner that the patient understands. Surveyors do not assess compliance with these requirements on limited English proficiency, but may refer concerns about possible noncompliance to the Office for Civil Rights in the applicable Department of Health and Human Services Regional Office.*

*Hospitals are expected to take reasonable steps to determine the patient's wishes concerning*

# Patient Notified of their Patient Rights 117

- **The standard:** A hospital must inform the patient, and when appropriate, the patient representative (PR) of the patient's rights in advance of furnishing or discontinuing patient care
- All inpatients and outpatients must be informed of their rights as hospital patients
- This has to be provided and explained in a language or manner that the patient or the PR can understand
- This brings in the issue of low health literacy and limited English proficiency (the use of interpreters)

# Limited English Proficiency or LEP

- Limited English proficiency is abbreviated LEP
- LEP means the patient is unable to communicate effectively in English
  - Because their primary language is not English
  - And they have not developed fluency in the English language
  - For example, the patient may speak Spanish and no English at all or limited English
- The US Department of Health and Human Services (HHS) has resources on the Office of Civil Rights (OCR) website
  - <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/>

# Civil Rights

Office for Civil Rights

Civil Rights

Health Information Privacy

OCR Home > Civil Rights > Resources > Special Topics > LEP

## Civil Rights

Clearance for Medicare Provider Applicants

Understanding Civil Rights

Enforcement Activities and Results

### Resources

Fact Sheets

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### Special Topics

Adoption Foster Care

Community Living & Olmstead

Emergency Preparedness

Health Disparities

HIV/AIDS

Hospitals & Effective Communication

### LEP

National Origin Discrimination

Temporary Assistance for Needy Families

## Limited English Proficiency (LEP)



This section includes documents pertaining to persons with Limited English Proficiency (LEP). This means persons who are unable to communicate effectively in English because their primary language is not English and they have not developed fluency in the English language. A person with Limited English Proficiency may have difficulty speaking or reading English. An LEP person will benefit from an interpreter who will translate to and from the person's primary language. An LEP person may also need documents written in English translated into his or her primary language so that person can understand important documents related to

health and human services. Information on OCR's work in the area of nondiscrimination on the basis of national origin can be found at [www.hhs.gov/ocr/nationalorigin](http://www.hhs.gov/ocr/nationalorigin).

### LEP Resources and Tools

- [Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons - \[En Español\]](#)
- [Questions and Answers Regarding the Department of Health and Human Services Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons](#)
- [Summary of the Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons](#)
- [Fact Sheet on Guidance to Federal Financial Assistance Recipients Regarding](#)

### Teaming up for Language Access Education



- Improving Patient-Provider Communication Video [Part1](#) [Part2](#) [Part3](#) [Part4](#)
- [\(CC\) video available on request](#)
- [HHS Press Release - 11/7/09](#)

# Limited English Proficiency or LEP

- There are 55 million Americans whose primary language is not English and 90 million with low health literacy
  - So we need to provide qualified or certified interpreters to patients and put things in easy to understand language
- We need to provide interpreters at critical parts of their care such as discharge instructions, doing the H&P, consent etc.
- Be sure to document the use of an interpreter in the medical record
- Will help reduce unnecessary readmissions

# Low Health Literacy or LHL

- 20% of patients read at a fifth grade level
- Another 20% read at an eighth grade level
- 52% of patients were unable to read or understand their discharge instructions or medication sheets
- So we need to provide information in a manner the patient can understand
- Can do teach back and ask the patient to repeat the information back to make sure they understand it
- Ask me three is a good way to keep information basic

# Ask Me Three Good Communication

Ask  
Me3™



Nothing — not age, income, employment status, educational level, and racial or ethnic group — affects health status more than **literacy skills.**

That's why clear communication between patients and health care providers is critical.

Good communication =  
Healthy patients

**Start with Ask Me 3.**

[www.npsf.org/  
askme3](http://www.npsf.org/askme3)

**Ask Me 3** is a patient education program designed to promote communication between health care providers and patients in order to improve health outcomes. The program encourages patients to understand the answers to three questions:

1. **What is my main problem?**
2. **What do I need to do?**
3. **Why is it important for me to do this?**

Patients should be encouraged to ask their providers these three simple but essential questions in every health care interaction. Likewise, providers should always encourage their patients to understand the answers to these three questions.

# Provide Patient a Copy of Their Rights 117

- Hospitals are expected to take reasonable steps to determine the patient's wishes concerning designation of a representative
- If the patient is **not** incapacitated can still orally or in writing designate another to be their representative
  - Recommend you get it in writing
- Hospital must give this person **and** the patient the required notice of patient rights
- This is a change and the first time that the patient rights must be given not only to a competent patient but also to their representative

# The Exact Language Tag 117

Hospitals are expected to take reasonable steps to determine the patient's wishes concerning designation of a representative. Unless prohibited by applicable State law:

- When a patient who is not incapacitated has designated, either orally to hospital staff or in writing, another individual to be his/her representative, the hospital must provide the designated individual with the required notice of patients' rights **in addition to the patient**. The explicit designation of a representative takes precedence over any non-designated relationship and continues throughout the patient's inpatient stay or outpatient visit, unless expressly withdrawn, either orally or in writing, by the patient.

# Visitation Interpretive Guidelines 117

- If the patient is incapacitated and an individual presents with an AD or durable power of attorney then hospital proceeds with its P&P
  - This designation takes precedence over any non-designated relationship and continues throughout stay
  - In other word, the written advance directive take precedence over anyone who shows up and says they are the patient representative and wants to make healthcare decisions

# Visitation Interpretive Guidelines 117

- If incapacitated and unable to state wishes and no ADs and person asserts is spouse or domestic partner (including same sex partners) hospital is expected to accept without demanding supporting documentation
  - However, if more than one person claims to be the patient representation (PR) then appropriate to ask for documentation to support their claim
  - Such as proof of marriage, domestic partnership, joint household, co-mingled finances
  - State law can specify a procedure for determining who is a patient representative if patient incapacitated

# The Exact Language 117

- In the case of a patient who is incapacitated, when an individual presents the hospital with an advance directive, medical power of attorney or similar document executed by the patient and designating an individual to make medical decisions for the patient when incapacitated, then the hospital must, when presented with the document, provide the required notice of its policies to the designated representative. The explicit designation of a representative takes precedence over any non-designated relationship and continues throughout the patient's inpatient stay or outpatient visit, unless the patient ceases to be incapacitated and expressly withdraws the designation, either orally or in writing.
- **When a patient is incapacitated** or otherwise unable to communicate his or her wishes, there is no written advance directive on file or presented, and an individual asserts that he or she is the patient's spouse, domestic partner (whether or not formally established and including a same-sex domestic partner), parent (including someone who has stood in loco parentis for the patient who is a minor child), or other family member and thus is the patient's representative, the hospital is expected to accept this

# Patient Rights

- **State laws** may specify a procedure for determining who may be considered a representative of an incapacitated patient
- State law can also specify when documentation is or is not required
- CMS says the hospital must adopt P&P to facilitate expeditious and non-discriminatory resolution of disputes about whether an individual is the patient's representative, given the critical role of the representative in exercising the patient's rights

# Survey Procedure 117

- Surveyor is to review the medical records and interview staff and patients or PR (as appropriate) to examine how the hospital determines whether the patient has a representative, who that representative is, and whether notice of patients' rights is provided as required to patients' representatives
- Ask patients to tell you what the hospital has told them about their rights
- Does staff know what steps to take to inform a patient about their patients' rights, including those patients' with special communication needs?

# Survey Procedure 117

- Determine the hospital's policy for notifying all patients of their rights, both inpatient and outpatient
- Determine that the hospital's policy provides for determining when a patient has a representative and who that representative is, consistent with this guidance and State law
- Determine that the information provided to the patients by the hospital complies with Federal and State law

# Survey Procedure

117

- How does the hospital communicate information about their rights to diverse patients, including individuals who need assistive devices or translation services
- Does the hospital have alternative means, such as written materials, signs, or interpreters (when necessary), to communicate patients' rights?
- Does staff know what steps to take to inform a patient about their patients' rights, including those patients' with special communication needs?
- Was the IM Notice given as required?

# Patient Representative

- A refusal by the hospital of a person requested to be treated as a patient representative must be documented in the medical record along with a specific basis for the refusal (117)
- IM Notice must be signed by Medicare patient or their representative (117)
- Patient who is not incapacitated must involve designated patient representative in the plan of care
- If incapacitated then DPOA makes medical decisions for patient or similar documents re a plan of care

# CMS IM Notice

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[www.cms.hhs.gov/bni/](http://www.cms.hhs.gov/bni/)

## Beneficiary Notices Initiative (BNI)

[FFS Revised ABN](#)

[FFS HHABN](#)

[FFS SNFABN and SNF Denial Letters](#)

[FFS HINNs](#)

[FFS ED Notices](#)

[MA Denial Notices](#)

[MA ED Notices](#)

[Hospital Discharge Appeal Notices](#)

[FFS NEMB SNF](#)

[Statutory Guidance](#)

## Beneficiary Notices Initiative (BNI)

Please Note: For Medicare Prescription Drug Coverage Notices -- see below under "Related Links Inside CMS."

### Beneficiary Notices Initiative

Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under the Fee-for-Service (FFS) Medicare and the Medicare Advantage (MA) Programs. These financial liability and appeal rights and protections are communicated to beneficiaries through notices given by providers.

Use the navigation tool on the left side of this page to link to the following financial liability notices and their instructions:

- FFS Revised Advance Beneficiary Notices (FFS Revised ABN)
- FFS Home Health Advance Beneficiary Notice (FFS HHABN)
- FFS Skilled Nursing Facility Advance Beneficiary Notice (FFS SNFABN) and SNF Denial Letters
- FFS Hospital-Issued Notice of Noncoverage (FFS HINNs)
- FFS Expedited Determination Notices for Home Health Agencies, Skilled Nursing Facility, Hospice and Comprehensive Outpatient Rehabilitation Facility (FFS ED Notices)

## Beneficiary Notices Initiative (BNI)

[FFS Revised ABN](#)

[FFS HHABN](#)

[FFS SNFABN and SNF Denial Letters](#)

[FFS HINNs](#)

[FFS ED Notices](#)

[MA Denial Notices](#)

[MA ED Notices](#)

**Hospital Discharge Appeal Notices**

[FFS NEMB SNF](#)

[Statutory Guidance](#)

## Hospital Discharge Appeal Notices

### Regulations

On November 27, 2006, the Centers for Medicare & Medicaid Services (CMS) published a final rule, CMS-4105-F: Notification of Hospital Discharge Appeal Rights. Beginning July 2, 2007, hospitals must deliver a revised version of the Important Message from Medicare to inform Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Notice is required both for Original Medicare beneficiaries and for those enrolled in Medicare health plans.

Beneficiaries who choose to appeal a discharge decision will receive a more detailed notice. The rule is posted below under "Downloads" along with the correction notice.

### Notices

The latest versions of the "Important Message from Medicare", Form CMS-R-193, and the "Detailed Notice of Discharge", Form CMS-10066, - updated as of July 20, 2010 - are posted below along with the manual instructions for this process. Please note that the latest version of the "Important Message from Medicare" requires hospitals to note the time of delivery. Hospitals and Medicare Advantage organizations (MAOs) may use these versions immediately, but use is not required until April 1, 2011. After April 1, 2011, the forms with approval dates of 05/07 will not be valid.

Note: The Notice of Hospital Requested Review (HRR), also known as HINN 10, has been relocated to the HINN web page and can be accessed by clicking on the "HINNs" link below.

### Downloads

[Important Message from Medicare - English and Spanish \[ZIP, 110KB\]](#)

[Detailed Notice of Discharge - English and Spanish \[ZIP, 59KB\]](#)

[CMS-4105 Manual Instructions \[ZIP, 47KB\]](#)

[Special Open Door Forum Presentation May 20 \[PDF, 2MB\]](#)

# Plan of Care 130

- Standard: The patient has the right to participate in the development and implementation of his or her plan of care
- Plan of care is important to CMS and TJC
- Need a written plan of care started soon after the patient is admitted and must be maintained in the medical record
- Patients and their PR have a right to participate in both the inpatient and outpatient plan of care including their discharge plan or pain management plan

# Plan of Care 130

- Hospitals are expected to take reasonable steps to determine the patient's wishes concerning designation of a representative to exercise the patient's right to participate in the development and implementation of the patient's plan of care
- If patient is incapacitated and unable to communicate and no ADs
- Then an individual who is the spouse or domestic partner, parent of minor child, and other family member **must** be involved in plan of care

# Plan of Care 130

- Express designation of a PR takes precedence
- CMS says should get it in writing or orally when patient is not incapacitated
  - Author recommends you get it in writing
- CMS says if patient is not incapacitated and has PR then must involved both in the patient's plan of care
- Again important to note that both must be involved in the plan of care
- If patient is incapacitated then the person with the AD gets to make decisions re the plan of care

# Plan of Care 130

- If patient is incapacitated and no AD on file then who ever asserts they are the PR such as spouse, domestic partner, parent of child, or other family member
- Hospitals are not expected to demand documentation unless more than one person claims to be the representative
  - Refusal to allow must be documented in the medical record along with the refusal
  - State law can define this as far as order of priority
  - Must have P&P on this

# Plan of Care Survey Procedure 130

- Does the hospital have a P&P to involve patient or their PR in the development of their plan of care for both inpatients and outpatients?
- Surveyor to review the medical record and interview staff to make sure they know this section on plan of care requirements
- Does the hospital P&P provide for determining when a patient has a representative who can exercise the patient's rights in implementing the plan of care
- Were revisions to the plan explained to the patient?

# Consent Informed Decisions 131

- Standard: the patients or their representatives has the right to make informed decisions regarding their care.
- This includes the right to be informed of their health status, be involved in the care planning, and can request or refuse treatment
- The right to make informed decisions means the patient is given information in order to be able to make this decision
- This is important to make sure informed consent is given

# Consent & Informed Decisions A 131

- Competent patient asks someone to be their representative, orally or in writing, then person must be given information on informed decisions about patient care
  - So both the patient is given information along with the PR
  - This included getting informed consent from them when required
- CMS states “The hospital must also seek the written consent of the patient’s representative when informed consent is required for a care decision.”

# Consent from Competent Patient & PR

*Hospitals are expected to take reasonable steps to determine the patient's wishes concerning designation of a representative. Unless prohibited by applicable State law:*

- *When a patient who is not incapacitated has designated, either orally to hospital staff or in writing, another individual to be his/her representative, the hospital must provide the designated individual with the information required to make an informed decision about the patient's care. The hospital must also seek the written consent of the patient's representative when informed consent is required for a care decision. The explicit designation of a representative by the patient takes precedence over any non-designated relationship and continues throughout the patient's inpatient stay or outpatient visit, unless expressly withdrawn, either orally or in writing, by the patient.*

# Consent & Informed Decisions 131

- Again suggest you get it in writing from the competent patient designating their PR
  - May want to include language about being a support person/visitation, decisions about who can visit, language making it clear that patient understands that medical record information (PHI) will be shared with PR
- Incapacitated and no AD then person who asserts is spouse, domestic partner, parent of child decides
- Incapacitated patient then consent is from the patient representative (DPOA, guardian, parent for child, designated representative, etc.)

# Consent & Informed Decisions A 131

- Same requirement about having a P&P in case there is a dispute so it can quickly be resolved
- Same provision if hospital refuses to let someone be treated as the PR then this must be documented in the medical record along with the specific refusal
- The right to know the diagnosis, prognosis, is afforded so informed decisions and informed consent can be obtained
- CMS has a section in the medical record and surgery section on what is required to be in the consent form

# Diagnosis Ownership 131

- Must notify patient if physician owned hospital
  - Must give list of owner if patient requests and this include family members of physicians who are owners
- Physicians must also notify all their patients if they are an owner or investor in the hospital before sending them to the hospital for test or procedures
  - Must do as condition for retaining MS privileges
  - Hospital must sign an attestation that there is no referring physician with an ownership or investment interest in the hospital along with no immediate family members (related to physician owned hospital only)

# Advance Directives

132

- In advance directive can delegate decision making to another person
- Patient may also delegate support person
  - Also referred to as the patient advocate
- Designation in the AD takes precedence
- Notice of the **hospital's AD policy** must be provided to inpatients when admitted at time of registration
  - Such as right to make an AD & document this in the MR
- Also to outpatients or their representatives in the **ED, observation** or undergoing same day surgery

# The Exact Language Tag 132

§489.102 also requires the hospital to:

- Provide written notice of its policies regarding the implementation of patients' rights to make decisions concerning medical care, such as the right to formulate advance directives. If an individual is incapacitated or otherwise unable to communicate, the hospital may provide the advance directive information required under §489.102 to the individual's "family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law." (§489.102(e)) The guidance concerning the regulation at §482.13(a)(1) governing notice to the patient or the patient's representative of the patient's rights applies to the required provision of notice concerning the hospital's advance directive policies. Although both inpatients and outpatients have the same rights under §482.13(a)(1), §489.102(b)(1) requires that notice of the hospital's advance directive policy be provided at the time an individual is admitted as an inpatient. However, in view of the broader notice requirements at §482.13(a)(1), the hospital should also provide the advance directive notice to outpatients (or their representatives) who are in the emergency department, who are in an observation status, or who are undergoing same-day surgery. The notice should be presented at the time of registration. Notice is not required for other outpatients, given that they are unlikely to become incapacitated.

# Notify Family or Representative 133

- Hospital must ask every patient who is admitted if they want to notify a family member or patient representative about the admission
- Hospital must ask EVERY patient if they want their own physician notified unless already aware of this
- If patient is incapacitated then hospital must notify family member
- If spouse, domestic partner, parent of child, or other family member comes to the hospital is expected to accept unless more than one claim and then can ask for documentation

# Notification of Family and Physician 133

- Hospital must have P&P to facilitate quick resolution of issues of disputes
- Hospital can choose to provide notice to more than one family member
- If patient is incapacitated must promptly notify patient's own physician if can be reasonably identified
- Hospital must document that the patient was asked if wanted family and physician notified
  - Be sure to have P&P on notification of family and physician

- Need written P&P regarding visitation including any clinically necessary or reasonable restrictions
- Supports open visitation even in the ICU
- Hospital P&P must include the reasons for any restrictions or limitations
- There are reasons to restrict or limit visitation and include but are not limited to the following;
  - There may be infection control issues
  - Visitation may interfere with the care of other patients

# Reasons to Restrict Visitors 215

- The hospital is aware that there is an existing court order restricting contact
- Visitors engage in disruptive, threatening, or violent behavior of any kind
- The patient or patient's roommate need rest or privacy
- In the case of an inpatient substance abuse treatment program, there are protocols limiting visitation and
- The patient is undergoing care interventions

# Reasons to Restrict Visitors 215

- May establish minimum age requirement for child visitors
- Burden is on the hospital to establish that the restriction is necessary for safe care
- Policy must have clear explanation of the rationale for visitor restrictions in their policy
- Policy must address how staff will be trained to assure proper implementation of visitor P&P
- Need to document training done of staff

# Informing the Patient 216

- Must inform each patient of their visitation rights or support person when appropriate
- Patient can withdrawal consent for visitors at anytime
- If patient is incapacitated or unable to communicate then provide information to their advance directive designating a support person
  - Could be a visitation advance directive and can be different than the DPOA

# Advance Directives 216

- If no AD designating a representative then individual who asserts is spouse, domestic partner, parent of a child, or other family friend or family, the hospital will accept this without requiring proof
  - Unless more than one person claims to be the support person then ask for documentation
- Need to have non-discriminatory resolution of disputes
- Refusal to honor request of person to be treated as the support person must be documented in the medical record along with basis for refusal

# Incapacitated Patient with No AD

*When a patient is incapacitated or otherwise unable to communicate his or her wishes, there is no advance directive designating a representative on file, and no one has presented an advance directive designating himself or herself as the patient's representative, but an individual asserts that he or she, as the patient's spouse, domestic partner (including a same-sex domestic partner), parent or other family member, friend, or otherwise, is the patient's support person, the hospital is expected to accept this assertion, without demanding supporting documentation, provide the required notice of the patient's visitation rights, and allow the individual to exercise the patient's visitation rights on the patient's behalf. However, if more than one individual claims to be the patient's support person, it would not be inappropriate for the hospital to ask each individual for documentation supporting his/her claim to be the patient's support person.*

- Hospitals are expected to adopt policies and procedures that facilitate expeditious and non-discriminatory resolution of disputes about whether an individual is the patient's support person, given the critical role of the support person in exercising the patient's visitation rights.*

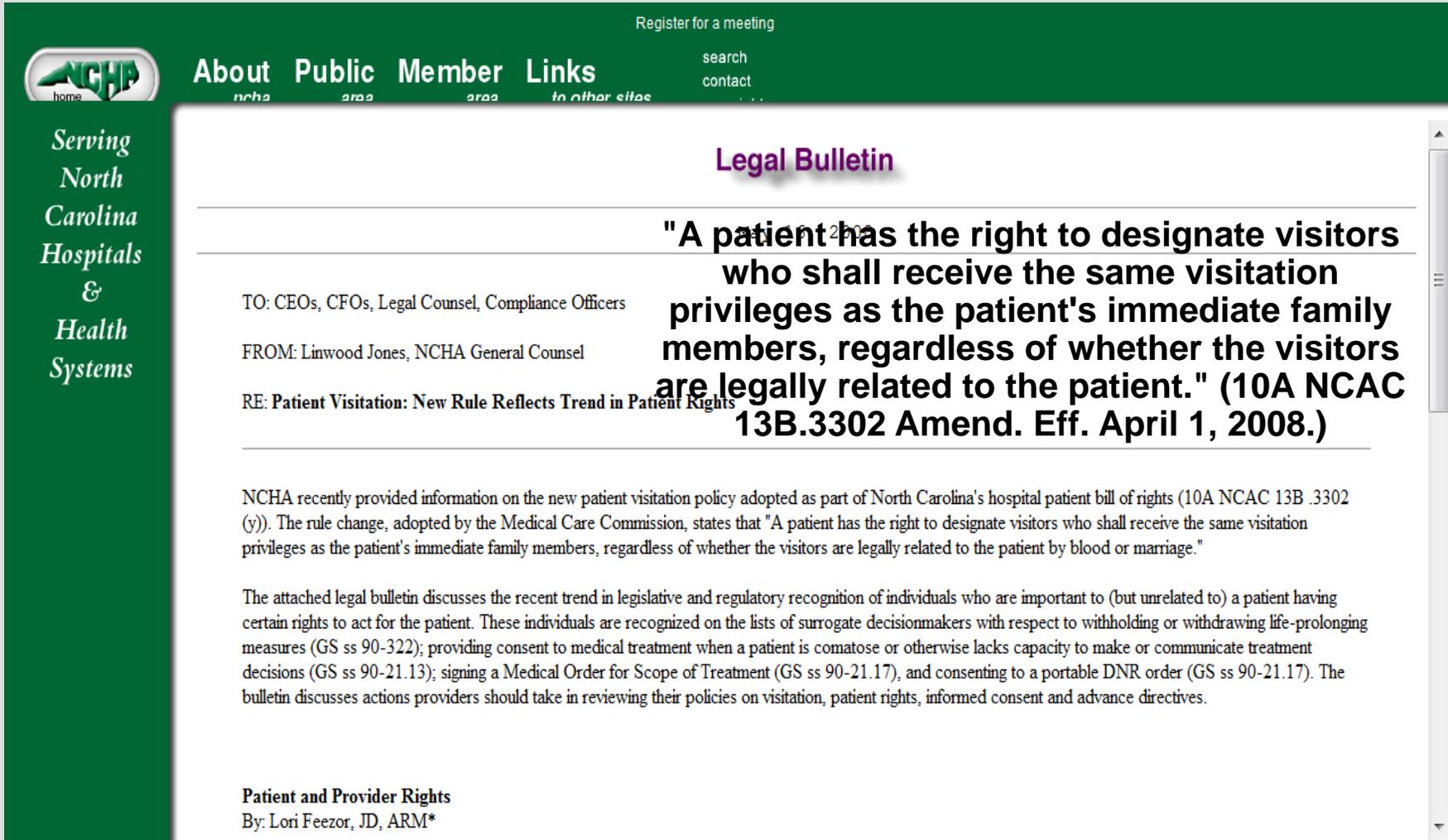
# Visitors 217

- All visitors enjoy full and equal visitation consistent with patient preferences
- Can not discriminate on basis of color, race, sexual orientation or gender identity
  - Make sure this is in your P&P
- Surveyor will review the hospital visitation policy to make sure it conforms with these standards
- Will ask hospital how it educated the staff on visitation policies and to make sure implemented in a non-discriminatory manner

# State Visitation Laws

- States like Delaware, Nebraska, North Carolina and Minnesota have adopted similar laws
- States that have passed a specific state law will need to review the final CMS Hospital CoP section
- Will need to contrast it with their state law requirement
- State law must be at least as stringent as CMS but okay if it is more stringent
- Consider consent and DNR issues with surrogate decision maker such as guardian or DPOA

# Patient Visitation North Carolina



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## Legal Bulletin

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**"A patient has the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient." (10A NCAC 13B.3302 Amend. Eff. April 1, 2008.)**

TO: CEOs, CFOs, Legal Counsel, Compliance Officers  
FROM: Linwood Jones, NCHA General Counsel  
RE: **Patient Visitation: New Rule Reflects Trend in Patient Rights**

---

NCHA recently provided information on the new patient visitation policy adopted as part of North Carolina's hospital patient bill of rights (10A NCAC 13B .3302 (y)). The rule change, adopted by the Medical Care Commission, states that "A patient has the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient by blood or marriage."

The attached legal bulletin discusses the recent trend in legislative and regulatory recognition of individuals who are important to (but unrelated to) a patient having certain rights to act for the patient. These individuals are recognized on the lists of surrogate decisionmakers with respect to withholding or withdrawing life-prolonging measures (GS ss 90-322); providing consent to medical treatment when a patient is comatose or otherwise lacks capacity to make or communicate treatment decisions (GS ss 90-21.13); signing a Medical Order for Scope of Treatment (GS ss 90-21.17), and consenting to a portable DNR order (GS ss 90-21.17). The bulletin discusses actions providers should take in reviewing their policies on visitation, patient rights, informed consent and advance directives.

**Patient and Provider Rights**  
By: Lori Feezor, JD, ARM\*

# Patient Visitation Rights In Summary

- All hospitals should inform all patients of their visitation rights in **writing** in advance of care furnished
- This includes the right to decide who may and may not visit them
- Some hospitals may give a one page sheet to each patient upon admission
  - Others include in written patient rights statement
- Hospitals would want to amend their patient rights statement to include this information
  - Example: written patient rights given to patients on admission and could have also brochure in admission packet

# Patient Visitation Rights In Summary

- Competent patients can verbally give this information on admission
- There is no requirement that designation of patient advocate be in writing if a competent patient gives oral confirmation as to who he or she would like to visit
  - However, recommend you have them sign a form
  - Some patients may sign a written patient visitation advance directive/support person
  - Some patients may add a section to their advance directive adding a section on who they would like to visit or deny visitation

# Patient Visitation Rights In Summary

- CMS does suggest that this be documented in the medical record for future reference if they specify a support person
  - Include the question in the admission assessment and ask during registration
- Reading of the Federal Register helps to provide an understanding of what it means and how to implement it
- CMS hospital interpretive guidelines should be incorporated into the hospital policy
- Train all staff on this

# Patient Visitation Right Restrictions

- Can still have restrictions or limitation if based on a clinically necessary or reasonable restrictions
- These must include these in your P&P
- CMS mentions 3 broad examples of where hospitals may want to impose restrictions
  - When the patient is undergoing care interventions
  - When there may be infection control issues
  - When visitors may interfere with the care of other patients

# Patient Visitation Rights In Summary

- There are other obvious areas where restrictions or limitation of visitation would be appropriate
- Be sure to state in the P&P that it is impossible to delineate or anticipate every clinical reason that could warrant restrictions or limitations
- The hospital reserves the right to determine any other situation where it is necessary to limit visitation
- Other clinically appropriate or reasonable restrictions to visitation might include:

# Patient Visitation Right Restrictions

- Disruptive behavior of the visitor
- Patient or room mate need for privacy (especially during procedures or tests)
- Care of other patients in a shared room such as the room mate
- Court order limiting or restraining contact
- Substance abuse treatment protocols requiring restricted visitation in the plan of care
- Behavior presenting a direct risk or threat to other patients or staff

# Patient Visitation Rights In Summary

- Failure to follow the visitation regulation could result in the hospital's loss of Medicare and Medicaid reimbursement
- Could file a grievance against the hospital or a complaint with the Joint Commission or accreditation organization (DNV, CIHQ, or AOA)
- Mentions Title VI of the Civil Rights Act of 1964
  - Patients must be notified in writing of the right to receive visitors of their choosing before care is furnished
  - Regarding patients with limited English proficiency need to provide notice in a manner and language that patients can understand

# Patient Visitation Rights In Summary

- CMS said in FR no requirement to have wall signage but hospitals can post this if on their own volition
- CMS does not have any particular format
- Hospitals are encouraged during the staff training sessions to address issues of cultural competence specific to the needs of individual patients
- May want to add to the P&P if 2 or more individuals claim to be the patient's support person if the patient is incapacitated
  - Person may need to leave to obtain written documentation of the patient's wishes

# So What's in Your Policy?

## ALLINA HOSPITALS & CLINICS TEMPORARY System-wide Policy

<b>Department:</b> All Allina Hospitals	<b>Policy Title:</b> Patient visitation during infectious disease outbreaks
<b>Page:</b> 1 of 3	<b>Effective Date:</b> 11/02/09
<b>Approved by:</b> Allina Infection Prevention and Control Council, Allina Infection Control Practitioners, Business unit IC committees	<b>Review Date:</b>
<b>Reference Number:</b>	<b>Revised:</b>

**Scope:** This policy is applicable to all Allina Hospitals and augments existing facility level policies covering the same or similar content.

**Purpose:** To provide system-wide guidance regarding patient visitation during the H1N1 pandemic and other times when there is on-going transmission of infectious disease in the community, and unrestricted visitation could place our patients at risk.

### **Policy:**

The following visitation restrictions are implemented when there is on-going transmission of infectious disease in the community, and there is a need to protect the health of our patients on OB and pediatric units and throughout the hospital and our staff. Individual hospitals may implement stricter restrictions as required based on community prevalence and patient population.

### **Procedure**

#### **General Hospital**

##### **I. Visiting hours**

A. Visiting hours are limited to: 9 a.m. to 8 p.m.

1. Compassionate exceptions will be made on a case by case basis with consultation from administrative/patient flow supervisor. Evaluate clinical nature of patient's condition, and grant exceptions based on critical condition/ prognosis.

# Considerations

- Restrictions for chemo patients for visitors with fever, cough, or cold like symptoms
- Restrictions for pandemic flu or other infectious disease outbreaks
- Any limitations on age such as no visitors under the certain age as in children under 12 with exceptions
- How many visitors are allowed and what about doula?
- Patients in Isolation, visitor behavior that presents a direct threat to staff or other patients
- Prison guarded patients, disruptive visitors, privacy or rest issues for the roommate

# Considerations

- Pastoral care visit or clergy visits
- Over night stays, substance abuse treatment protocols on restricted visitation
- Recall under the federal HIPAA law if patients read the Notice of Privacy Practices and elect to be a no publicity
  - This means the patient is not listed in the directory so if anyone calls then the hospital will say “I’m sorry that patient is not listed in the directory”
  - Hospitals may decline mail or flowers also

# Visitation Rights

- Current hospice CoP allows visitors at any hour including small children
- Current LTC CoP (swing beds) allows residents to receive visitors any time or to withdraw or deny consent to visit for immediate family members
- So would need written P&P on visitation including any reasonable limitations and if justified
- Each patient must be informed of their right to receive visitors they want whether friend or family
  - Denial of visitation only if health and safety of the patient are effected

# The End! Questions?



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Phone questions only, No emails

# Visitation 1001 CAH

- Support person does not have to be the same person as the DPOA
- Support person can be friend, family member or other individual who supports the patient during their stay
  - TJC calls it a patient advocate
- Support person can exercise patient's visitation rights on their behalf if patient unable to do so

# TJC Help Prevent Errors in Your Care



Ask a trusted family member or friend to be your advocate (advisor or supporter).

- Your advocate can ask questions that you may not think about when you are stressed. Your advocate can also help remember answers to questions you have asked or write down information being discussed.
- Ask this person to stay with you, even overnight, when you are hospitalized. You may be able to rest better. Your advocate can help make sure you get the correct medicines and treatments.
- Your advocate should be someone who can communicate well and work cooperatively with medical staff for your best care.
- Make sure this person understands the kind of care you want and respects your decisions.
- Your advocate should know who your health care proxy decision-maker is; a proxy is a person you choose to sign a legal document so he or she can make decisions about your health care when you are unable to make your own decisions. Your advocate may also be your proxy under these circumstances. They should know this ahead of time.
- Go over the consents for treatment with your advocate and health care proxy, if your proxy is available, before you sign them. Make sure you all understand exactly what you are about to agree to.
- Make sure your advocate understands the type of care you will need when you get home. Your advocate should know what to look for if your condition is getting worse. He or she should also know who to call for help.

# Visitation 1001 CAH

- Hospital must accept patient's designation of an individual as a support person
  - Either orally or in writing
  - Suggest you get it in writing from the patient
- When patient is incapacitated and no advance directives on file then must accept individual who tells you they are the support person
  - Must allow person to exercise and give them notice of patients rights and exercise visitation rights

# Visitation 1001 CAH

- Hospital expected to accept this unless two individuals claim to be the support person then can ask for documentation
  - This includes same sex partners, friends, or family members
  - Need policy on how to resolve this issue
- Any refusal to be treated as the support person must be documented in the medical record along with specific reason for the refusal

# Visitation 1001 CAH

- Patient can withdraw consent and change their mind
- Must document in the medical record that the notice was given
- Surveyor is to look at the standard notice of visitation rights
- Will review medical records to make sure documented
- Will ask staff what is a support person and what it means

# Visitation 1002

- Must have written P&P
- Must not restrict visitors based on race, color, sex, gender identify, sexual orientation etc.
- In other words, if a unit is restricted to two visitors every hour the patient gets to pick their visitors not the hospital
- Suggest develop culturally competent training programs

# Patient Visitation Rights

- Mentioned the JAMA article published in 2004 on Restricting Visitation Hours in ICU: A Time to Change <sup>1</sup>
  - Restricting hours is neither caring, compassionate or caring
  - Gives history of regulating visitor hours
  - Discusses the health and safety benefits of open visitation
- 1 <http://jama.ama-assn.org/cgi/content/full/292/6/736>

# JAMA Restricted Visiting Hours in ICU

- Too many hospitals have restricted ICU visiting hours
- Despite patient rights and ability for patients to make their own decisions
- Who is visiting whom?
- Discusses IHI challenge to open up ICUs
- Recent experiences show three initial concerns did not materialize (would cause patient stress, interfere with care, and exhaust family and friends)
- <http://jama.ama-assn.org/cgi/content/full/292/6/736>

# Visitation Rights

- IHI challenged a number of hospitals working on improvement to open their ICUs by having unrestricted visiting hours ( as discussed)
- Several hospitals instituted this and came forth to share what they had learned from open hours
- Literature shows presence of family and friends can reduced physiologic stress lowering BP, heart rate and intracranial pressure
- Patients should be allowed to determine visiting hours

# Visitation Rights JAMA article

- Articles discusses the pros and cons
- Does a review of the literature
- Bottom line is evidence shows the problems of open visitation is overstated and is manageable
- Provides support system for patients and families
- Friends and family tends to reassure and soothe the patients
- Notes that this may not be appropriate for every patient

# Visitation Rights JAMA Article

- Found that open visitation ICU hours did not provide a barrier to care
- Did not make it more difficult for nurses and doctors to do their jobs
- Families and friends were a helpful support system
- Helped with patient education
- Gave better feed back then the patient could give
- Okay to stipulate no visitation during procedures or treatments or emergencies (ACEP and ENA position of family presence during codes)

Vol. 292 No. 6, August 11, 2004

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Commentary

## Restricted Visiting Hours in ICUs

### Time to Change

Donald M. Berwick, MD, MPP, FRCP; Meera Kotagal, BA

*JAMA*. 2004;292:736-737.

The sickest patients lie in intensive care units (ICUs) facing fearful illness; surrounded by overwhelming noise from pulsating ventilators and monitors; invaded by the necessary ministrations of nurses; and overhearing, if they are awake, strange and portentous conversations. Professionals buzz about them, but these patients are mostly alone, separated from those who love them by restrictive ICU visiting policies, except at rigidly specified times or with the doled-out permission of the ICU staff. Restricting visiting in ICUs is neither caring, compassionate, nor necessary.

Restricted hospital visiting hours began in the late 1800s for nonpaying patients in an attempt to establish order in the general wards.<sup>1</sup> For many decades afterward, paying patients remained free to have visitors at almost any time in their private or semi-private rooms. In the 1960s, however, in an effort to protect the patient and the family from exhaustion

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## Don Berwick's Challenge: Eliminate Restrictions on Visiting Hours in the Intensive Care Unit

**Donald Berwick, MD, MPP**

*President and CEO, Institute for Healthcare Improvement  
Boston, Massachusetts, USA*



I would like to make a rather bold suggestion regarding "visiting hours" in critical care units. After several years of work in the [IOM "Chasm" report](#) context, ongoing instruction from Susan Edgman-Levitan and other true experts in authentic "patient-centeredness," many exchanges with scholars in service industries, and study of leading-edge redesign efforts like Planetree, I have come to believe strongly that visiting restrictions of any type in intensive care units are relics, which will be proven to be unnecessary, and potentially even harmful to the trajectory of healing, communication, and patient safety.

**My challenge is that some hospitals execute a two-month trial**

# Restricted Visiting Hours in ICUs

## Time to Change

Donald M. Berwick, MD, MPP, FRCP

Meera Kotagal, BA

**T**HE SICKEST PATIENTS LIE IN INTENSIVE CARE UNITS (ICUs) facing fearful illness; surrounded by overwhelming noise from pulsating ventilators and monitors; invaded by the necessary ministrations of nurses; and overhearing, if they are awake, strange and portentous conversations. Professionals buzz about them, but these patients are mostly alone, separated from those who love them by restrictive ICU visiting policies, except at rigidly specified times or with the doled-out permission of the ICU staff. Restricting visiting in ICUs is neither caring, compassionate, nor necessary.

Restricted hospital visiting hours began in the late 1800s for nonpaying patients in an attempt to establish order in the general wards.<sup>1</sup> For many decades afterward, paying patients remained free to have visitors at almost any time in their private or semi-private rooms. In the 1960s, however, in an effort to protect the patient and the family from exhaustion caused by too many visitors (Kenneth Ludmerer, MD, Washington University, oral communication, April 23,

cused on 3 worries: increased physiologic stress for the patient, interference with the provision of care, and physical and mental exhaustion of family and friends. While these concerns may seem reasonable, the evidence from the recent experiences at hospitals working with IHI, as well as from a small but growing body of literature, tell quite a different story.

*Physiologic Stress for the Patient.* The concern that the patient should be left alone to rest incorrectly assumes that family presence at the bedside causes stress. The empirical literature suggests that the presence of family and friends tends to reassure and soothe the patient, providing sensory organization in an overstimulated environment and familiarity in unfamiliar surroundings.<sup>3</sup> Visits of family and friends do not usually increase patients' stress levels, as measured by blood pressure, heart rate, and intracranial pressure, but may in fact lower them. Nursing visits, on the other hand, often increase stress.<sup>4,5</sup>

However, liberalizing visiting hours may not be good for every patient. The goal is not universal implementation of unrestricted ICU visiting policies, but rather the achievement of patients' control over the circumstances of their own care. It is important that patients be able to decide who can

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Letters

## Restrictions on Family Presence in the ICU

Since this article does not have an abstract, we have provided the first 150 words of the full text and any section headings.

**To the Editor:** The Commentary by Dr Berwick and Ms Kotagal<sup>1</sup> suggests that (presumably adult) intensive care units (ICUs) should allow unrestricted visiting hours for families despite perceived barriers to such change, including exacerbation of physiologic stress to the patient, interference with provision of care, and family exhaustion. The pediatric ICU (PICU) at my institution has allowed unlimited visiting hours for parents and family members for more than a decade. Parents are allowed to sleep in their child's room on fold-out comforters. We limit the number of visitors to 2 persons at a time primarily because of room size constraints. I believe that the concerns used to support visiting hour restrictions are completely mitigated when unlimited visitation is permitted.

The calming influence of family is readily apparent to the PICU clinical staff when caring for critically ill children and adolescents. Families even participate in minor care such as bathing or . . . [\[Full Text of this Article\]](#)

Richard J. Brill, MD  
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Cincinnati Children's Hospital Medical Center  
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# CMS Visitation Sept 7, 2011

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
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Baltimore, Maryland 21244-1850



Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group

Ref: S&C: 11-36-Hospital/CAH

**DATE:** September 7, 2011  
**TO:** State Survey Agency Directors  
**FROM:** Director  
Survey and Certification Group  
**SUBJECT:** Hospital Patients' Rights to Delegate Decisions to Representatives; New Hospital and Critical Access Hospital (CAH) Patient Visitation Regulation

[www.cms.gov/SurveyCertificationGeneralInfo/PMSR/list.asp#TopOfPage](http://www.cms.gov/SurveyCertificationGeneralInfo/PMSR/list.asp#TopOfPage)

## Memorandum Summary

- **President's Directive:** On April 15, 2010 the President issued a memo concerning hospital visitation and designation of representatives.
- **Clarification of Patients' Rights Concerning Designation of Representatives:** Hospitals are obligated under certain circumstances to extend patients' rights to patients' representatives. The Centers for Medicare & Medicaid Services (CMS) expects hospitals to give deference to patients' wishes concerning their representatives, whether expressed in writing, orally, or through other evidence. Hospital Appendix A is being revised to clarify the applicable requirements.
- **Hospital Visitation Policies:** CMS has amended the hospital and CAH Conditions of Participation (CoPs) to require protection of a patient's right to have and designate visitors. Hospital Appendix A and CAH Appendix W are being updated accordingly.

On April 15, 2010 the President issued a memorandum to the Secretary of Health and Human Services (copy enclosed) directing the initiation of rulemaking to ensure that hospitals respect the right of patients to have and designate visitors. The memorandum also directs the Secretary to issue guidance that clarifies existing regulatory requirements at 42 CFR 482.13, governing the

# Visitation 1000 CAH Manual

- Must have P&P and process on visitation
  - Including any reasonable restrictions or limitations
- Discusses 2004 JAMA article encouraging open visitation in the ICU
- Includes inpatients and outpatients
  - Discusses role of support person for both
  - Patient may want support person present during pre-op preparation or post-op recovery
  - Tag 1000 comes before Tag 295 in the CAH manual

# Reasonable Restrictions 1000 CAH

- Infection control issues
- Can interfere with the care of other patients
- Court order restricting contact
- Disruptive or threatening behavior
- Room mate needs rest or privacy
- Substance abuse treatment plan
- Patient undergoing care interventions
- Restriction for children under certain age

# Visitation 1000 CAH

- Need to train staff on the P&P
- Need to determine role staff will play in controlling visitor access
- Surveyor will verify you have a P&P
- Will review policy to determine if restrictions
- Is there documentation staff is trained?
- Will make sure staff are aware of P&P on visitation and can describe the policy for the surveyor

# Visitation 1001 CAH

- Must inform each patient or their support person, when appropriate, of their visitation rights
- Must include notifying patient of any restrictions
- Patient gets to decide who their visitors are
- Can not discriminate against same sex domestic partners, friend, family member etc.
- The patient gets to decide

# Resources

- Rosenberg CE. *The Care of Strangers: The Rise of America's Hospital System*. Baltimore, Md: Johns Hopkins University Press; 1987
- A challenge accepted: open visiting in the ICU at Geisinger, [www.ihl.org](http://www.ihl.org)
- Marfell JA, Garcia JS. Contracted visiting hours in the coronary care unit: a patient-centered quality improvement project. *Nurs Clin North Am*. 1995;30:87-96 at <http://www.ncbi.nlm.nih.gov/pubmed/7885927?dopt=Abstract>

# Resources

- Gurley MJ. Determining ICU visitation hours. *Medsurg Nurs.* 1995;4:40-43 at <http://www.ncbi.nlm.nih.gov/pubmed/7874220?dopt=Abstract>
- Krapohl GL. Visiting hours in the adult intensive care unit: using research to develop a system that works. *Dimens Crit Care Nurs.* 1995;14:245-258 at <http://www.ncbi.nlm.nih.gov/pubmed/7656767?dopt=Abstract>
- Simon SK, Phillips K, Badalamenti S, Ohlert J, Krumberger J. Current practices regarding visitation policies in critical care units. *Am J Crit Care.* 1997;6:210-217  
[http://ajcc.aacnjournals.org/cgi/content/abstract/6/3/210?ijkey=e4ebfadff6f205451545c622736f88ef98f36485&keytype2=tf\\_ipsecsha](http://ajcc.aacnjournals.org/cgi/content/abstract/6/3/210?ijkey=e4ebfadff6f205451545c622736f88ef98f36485&keytype2=tf_ipsecsha)



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Critical Care Nurse. 2005;25: 72-70

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## In Our Unit

# Process Helped Gain Acceptance for Open Visitation Hours

Marilyn Petterson

*"In Our Unit" highlights unique practices, innovations, research, or resourceful solutions to commonly encountered problems in critical care areas and settings where critically ill patients are cared for. If you have an idea for an upcoming "In Our Unit," send it to CRITICAL CARE NURSE, 101 Columbia, Aliso Viejo, CA 92656; fax, (949) 362-2049; e-mail, [ccn@aacn.org](mailto:ccn@aacn.org).*

One nurse's vision that, in addition to quality care, patients need the support and reassurance that only family members can bring them resulted in implementation of an open family visitation policy in the intensive care unit (ICU) at St. John's Mercy Medical Center, St. Louis, Mo.

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#### Several reasons for opening the visiting hours.

- Patients in the ICU are often critical or at the end stages of their lives. Families need to be together at such a time without restrictions.
- Positive reinforcement for critically ill patients is vital, so it is best for family members to be present when they are needed—at anytime around-the-clock.
- Family members working long days or untraditional hours, including healthcare workers, need to be able to visit at different times during the day and night.
- As a trauma center, St. John's Mercy often receives patients who are not from the immediate area or whose families are traveling long distances to be with them. When patients are admitted, the first thing their families want to do is see them. Open visiting hours allow them this comfort.
- Because critically ill patients need plenty of rest, open visiting hours allow family members to rotate in and out of the room according to the patient's needs instead of the clock.

# Breaking Down Barriers

- Document states that lesbian, bisexual, gay, and transgender (same sex) families face discrimination when attempting to access healthcare system
- Includes visitation access and medical decision making during emergencies and end of life care
- Human Rights Campaign Foundation administers the Healthcare Equity Index of healthcare policies and procedures and identifies best practices and policies with equal treatment



HUMAN  
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## **BREAKING DOWN BARRIERS: AN ADMINISTRATOR'S GUIDE TO STATE LAW & BEST POLICY PRACTICE FOR LGBT HEALTHCARE ACCESS**

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By Matthew Stiff, J.D., for the HRC Foundation  
Updated June 2010

### **INTRODUCTION AND SUMMARY OF RECOMMENDATIONS**

Lesbian, gay, bisexual and transgender (“LGBT”) families often face discrimination when attempting to access the American healthcare system. This discrimination sometimes results in the denial of hospital **visitation** access and in various restrictions on the medical decision-making rights of LGBT families. Because visitation access and medical decision-making can become critical during emergency and end-of-life medical care, this disparate treatment can have tragic consequences for LGBT families.<sup>1</sup>

The problems confronting LGBT families in the American healthcare system are deeply rooted in bias and ignorance. Erasing these inequities requires a coordinated and multi-pronged response on the part of healthcare administrators, medical staff and the LGBT community. To identify policy solutions to these problems, the Human Rights Campaign Foundation (“HRC Foundation”) administers the Healthcare Equality Index (“HEI”), an annual survey of healthcare industry policies and practices related to LGBT individuals and their families. The goals of the HEI are 1) to benchmark healthcare facilities on identified best practices and policies with respect to equal treatment of LGBT individuals and families and 2) to share, implement and recognize these best practices with healthcare industry leaders.

Now in its fourth year, the HEI counts some of the world’s most prestigious healthcare institutions as survey participants.<sup>2</sup> In 2009, for the first time in the history of the HEI, these

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<sup>1</sup> See, e.g., *Langbehn v. Jackson Memorial Hospital*, Case No. 08-21813-CIV-JORDAN/McALILEY (Janice Langbehn and Lisa Pond were about to begin a family cruise with their three children in Miami when Pond suddenly collapsed; Jackson Memorial Hospital informed Langbehn she was in an antigay state and city and denied visitation access to see

general structure common to most policies emerges. This structure first establishes a definition of permitted visitors and then enumerates specific restrictions on an otherwise general grant of visitor access. Delineating permitted visitors is typically achieved by crafting a general definition of “family.” After this definition of “family” identifies permitted visitors, many hospitals then list certain limits on visitor access. These restrictions flow from the security, health and operational concerns of the hospital. For instance, safety concerns prompt many hospitals to restrict access to sensitive units (e.g. obstetrics and psychiatry), while health concerns lead many hospitals to prevent recently ill visitors from interacting with the patient population.

Given that defining “family” is the critical point of departure in crafting visitation policy, it is essential to the equal treatment of LGBT individuals that healthcare institutions adopt an explicitly LGBT-inclusive definition of “family.” Simply stated, “family” is greater than the sum of one’s biological and legal relationships.

Our policy review indicates that many leading healthcare institutions have already enacted LGBT-inclusive definitions of “family,” including hospitals located in states where LGBT individuals are otherwise afforded little in the way of legal protection. However, some hospitals continue to use either overly restrictive or amorphously broad definitions of “family.” Several administrators also have opined that written visitation policies are unnecessary. As a matter of operational integrity, the practice of many hospitals demonstrates that well-crafted visitation policies anticipate future problems, provide guidance to staff and minimize friction down the line.

### **Visitation Policy Recommendations**

The HRC Foundation encourages all healthcare institutions to embrace the example of their peers by adopting an explicitly inclusive definition of “family.” The following definition of “family” reflects leading hospital policy provisions and incorporates the expert advice of healthcare providers, hospital administrators and legal counsel:

- [HOSPITAL] adopts the following definition of “**family**” for purposes of hospital-wide visitation policy: “**Family**” means any person(s) who plays a significant role in an individual’s life. This may include a person(s) not legally related to the individual.

# Recommendations

- First establish a definition of permitted visitors
- Then enumerate restrictions on visitor access such as restriction to sensitive areas such as behavioral health unit or OB (infant security issues)
- Health concern restrictions such as preventing ill visitors
- Definition of family is critical and must be broad and encompass concept of family
- Provides a sample definition of family and recommendation for what should be in the P&P

# Definition of Family

- Family means any person who plays a significant role in an individual's life.
- This may include a person not legally related to the individual.
- Members of family include spouses, domestic partners, and both different-sex and same-sex significant others.
  - Family includes a minor patient's parents, regardless of the gender of either parent. Solely for purposes of visitation policy, the concept of parenthood is to be liberally construed without limitation as encompassing legal parents, foster parents, same-sex parent, step-parents, those serving in loco parentis, and other persons operating in caretaker roles.
- 36 Kaiser Permanente hospitals implemented them in June 2010

# Sample Visitation Authorization

## Hospital Visitation Authorization

I, \_\_\_\_\_, [name] a resident residing at \_\_\_\_\_  
\_\_\_\_\_ [home address], \_\_\_\_\_ County, State of \_\_\_\_\_, do hereby  
give notice and authorization that if I should be injured or fall ill or be incapacitated through any  
other cause that necessitates my hospitalization or treatment in a medical facility, it is my wish  
that \_\_\_\_\_ [name of person] be given first preference in being  
admitted to visit me in such medical or treatment facility, whether or not there are parties related  
to me by blood or by law or other parties desiring to visit me, unless and until I freely give  
contrary instructions to competent medical personnel on the premises involved.

Executed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, at \_\_\_\_\_  
\_\_\_\_\_ [location of signing].

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

### **Witnesses Signatures:**

Witness # 1

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Witness #2

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

**Forthcoming Federal Regulation:** On April 15, President Obama issued a memorandum directing the Department of Health and Human Services to adopt regulations requiring all hospitals receiving Medicaid and Medicare dollars to permit visitation by a designated visitor, without regard to sexual orientation or gender identity. These regulations are not yet in effect.



Hospital visitation laws can be in the form of relationship recognition laws (marriage, civil unions, domestic partnerships) or separate visitation statutes.

- States extending equal hospital visitation rights to same-sex spouses or partners through marriage equality or statewide relationship recognition. (10 states and D.C.)  
*California, Connecticut, District of Columbia, Iowa, Massachusetts, Nevada, New Hampshire, New Jersey, Oregon, Vermont and Washington.*
  
- States extending equal hospital visitation rights to same-sex spouses or partners through specific provisions as part of a limited relationship recognition statute. (5 states)  
*Colorado, Hawaii, Maryland, New York and Wisconsin.*
  
- States extend hospital visitation rights through a designated visitor statute. (8 states)  
*Delaware, Illinois, Kentucky, Minnesota, Nebraska, North Carolina, Virginia and West Virginia.*

\* Healthcare Agent Statute: Two states extend hospital visitation rights to a designated healthcare agent.

# American Hospital Associations



## PUT IT IN WRITING

Para Español

An advance directive is your life on your terms. Whether you're 18 or 80, documenting your wishes today means your family won't have to make heart-wrenching decisions later.

To help patients, families and the hospitals that serve them, the American Hospital Association (AHA), with the cooperation of other organizations, has compiled key resources to enhance educational efforts and raise awareness around this important issue.

We encourage everyone to talk with their family, their friends, their doctor. Know the options. Decide what's right for you. And then put it in writing.



**YOUR LIFE,  
YOUR  
TERMS**  
[Public Service  
Announcement](#)

See what others  
are saying...

### Links

#### ADVANCE DIRECTIVES FOR YOUR STATE

The National Hospice and Palliative Care Organization

This [page](#) offers free, state specific advance directives and advice for communicating wishes to family and close friends.

#### RELATED INITIATIVES

#### CONSUMER TOOL KIT FOR HEALTH CARE ADVANCE PLANNING

American Bar Association

This [website](#) contains a variety of self-help worksheets, suggestions, and resources that prompt a continuing conversation about values, priorities, the meaning of one's life, quality of life and what's important.

#### EASY TO READ AND USE ADVANCE DIRECTIVES

Aging with Dignity

### Resources

#### PUT IT IN WRITING BROCHURE

This AHA resource provides basic facts about advance directives and encourages patients to explore their preferences for care at the end of life.

[Full text brochure](#)  
[Glossary of terms](#)  
[Questions & answers](#)

[http://www.putitinwriting.org/putitinwriting\\_app/index.jsp](http://www.putitinwriting.org/putitinwriting_app/index.jsp)

# Visitation Expanded in the ED

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## The Joint Commission Update

In this column an expert from The Joint Commission provides an update for readers.

### Pediatric Safety in the Emergency Department Identifying Risks and Preparing to Care for Child and Family

*Deborah Nadzam, PhD, RN, FAAN;  
Francine Westergaard, MSN, RN*

**S**IGNIFICANT improvements in the understanding of patient safety problems and the development of interventions have occurred in adult medicine, but there is limited understanding of these issues in pediatrics. Pediatric patients pose challenges because of their physical size and proportion, limited ability to communicate, and rapid deterioration of their conditions if not quickly and appropriately treated, compounded by the fact that most medical devices and medications used to treat them have not been tested for this population.<sup>1</sup>

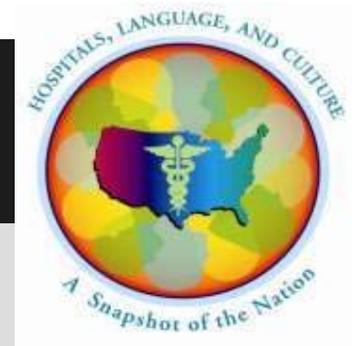
Several high-profile neonate medication errors in recent years have brought the issue of pediatric safety into public consciousness.

these children are seen at non-children's hospitals. The large percentage of children seen in EDs can be attributed to numerous causes, such as lack of a primary care physician and use of the ED as an alternative. Common pediatric presentations in the ED include respiratory emergencies such as asthma or croup, dehydration, shock, head injury, poisoning, seizures, and anaphylaxis. All such disorders can become life-threatening if not managed appropriately.<sup>3</sup>

Child-specific characteristics that may contribute to risk factors include the following:

- physical characteristics—small or varied size and differing morphology;
- developmental variance and ongoing

# The Joint Commission



## One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations Self-Assessment Tool – Accommodating the Needs of Specific Populations

- Have we considered ways to accommodate patients with large families?
33. How have we adapted our patient care services to incorporate cultural beliefs?
- Is there a need to modify visitation hours to accommodate patient needs?
  - How can we adjust our policies and procedures to accommodate cultural considerations?
  - Do our dietary menus reflect our commitment to diversity and culturally competent care?

### *Helping Patients Manage Their Care*



## One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations Self-Assessment Tool – Accommodating the Needs of Specific Populations

34. What programs do we have that help patients understand and navigate the health care system?



**This presentation is intended solely to provide general information and does not constitute legal advice. Attendance at the presentation or later review of these printed materials does not create an attorney-client relationship with the presenter(s). You should not take any action based upon any information in this presentation without first consulting legal counsel familiar with your particular circumstances.**

# Thanks for attending! Questions??



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