Hospice Accreditation Intensive

An Interactive Virtual Training

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Name – State – Fun Fact

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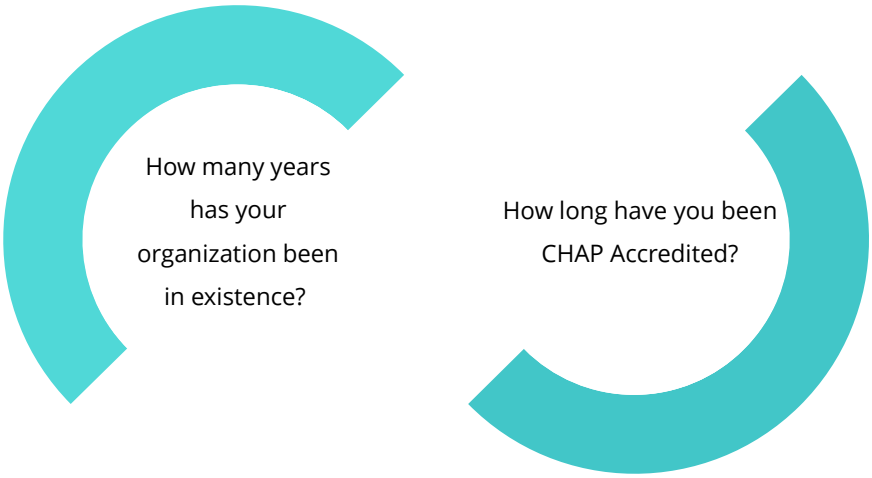
Get to Know You Using Microsoft Polls



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Housekeeping

- Introductions

Agenda and Handouts

- Muting
- Use of Chat
- Raise of hand

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Disclosures/Conflict of Interest

This nursing continuing professional development activity was approved by the Virginia Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

There are no conflicts of interest for any individual in a position to control content for this activity.

How to obtain CE contact hours:

Criteria for successful completion includes attendance at the entire event (both days), participation in engagement activities, completion of an evaluation and completion of the consulting exam.

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BW0

CHAP Standards of Excellence

- Revisions
- Version
- Evidence Guidelines

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Slide 6

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Additional Resources

- Appendix M and Appendix Z
- Medicare Administrative Contractor
- MLN newsletters and CHAP eNews

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Resource Tool Example

Standard	Summary of Content
HPFC 1.D	The hospice has a **Patient Bill of Rights** and Responsibilities
HPFC 2.D	**Required elements** of the Patient Bill of Rights
HPFC 3.I	**Provision** of the Bill of Rights during the initial assessment and **prior to care provision**
HPFC 4.I	**Patient right to exercise** their rights without discrimination or reprisal
HPFC 5.I	Addressing **patients not competent** to exercise their rights
HPFC 6.D	**Complaint** management process including policies and procedures
HPFC 7.D	Addressing **allegations** of verbal, mental, sexual, physical **abuse/mistreatment**
HPFC 8.D	Hospice **response to alleged** violations of **abuse/mistreatment** per policy
HPFC 9.D	Patient is informed and provided written instruction regarding **advanced directives**
HPFC 10.I	Advance Directive information provided at initiation of care and **documented**

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Hospice Patient/Family Centered Care (HPFC)

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Elements of the Patient Bill of Rights

- **Involvement** in development of the Plan of care
- **Informed of**
  - Scope of services
  - Limitations of those services
  - Hospice's advance directive policy
  - Services covered under the hospice benefit
- **Refuse** care or treatment
- **Choose** their own attending
- **Free from mistreatment**, neglect, verbal, mental, sexual or physical abuse, misappropriate of property and treated with respect
- Able to **voice grievances** regarding treatment provided or failed to provide
- **Confidentia**l record per law and regulation
- Received effective pain management and **symptom control**

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Other Patient Rights

HPFC 3.I-4.I
Rights provided verbally and in writing prior to providing care. Signature confirming receipt

HPFC 5.I
Incompetent patient

HPFC 6.D
Handling of complaints

HPFC 7.D-8.D
Requirements related to alleged violations of any type of abuse

HPFC 9.D – 10.I
Requirements related to advance directives

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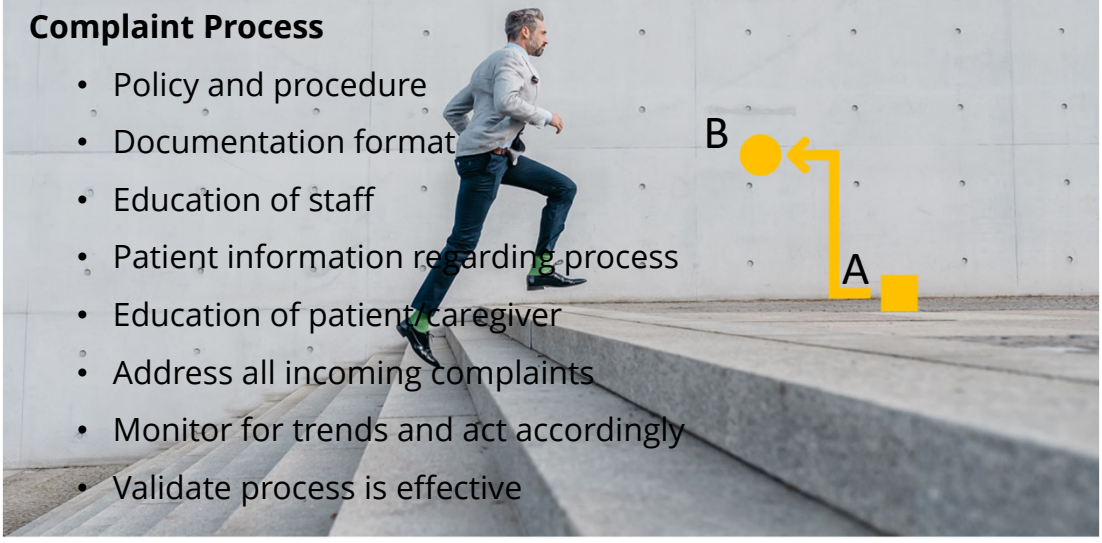
Implementation of Patient Rights

Complaint Process

- Policy and procedure
- Documentation format
- Education of staff
- Patient information regarding process
- Education of patient/caregiver
- Address all incoming complaints
- Monitor for trends and act accordingly
- Validate process is effective



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Top Findings in HPFC

Standard	Content	CMS Tag	% Cited
HPFC 10.I	Advance directive provided to patients	L503	36%
HPFC 1.D	Hospice has a bill of rights	L501	21%
HPFC 2.D	Elements to be present in the Patient Bill or Rights	L515, L503, L518	21%

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Top Findings in HPFC

HPFC 1.D; 415.82: Bill of Rights

L 501 *- The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.*

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Top Findings in HPFC

HPFC 10.1; 418.52(a): Advance Directives

L503 - *The hospice must inform and distribute written information to the patient concerning its policies on advance directives,* ***including a description of applicable State law***

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Top Findings in HPFC

HPFC. D2; 418.52(c)4; Elements of the Bill of Rights

L 503: *The hospice must inform and distribute written information to the patient concerning its* ***policies*** *on advance directives, including a description of applicable State law.*

L 515: *Right to choose their attending physician; have this person involved in their medical care in all hospice settings and the attending provides the care for the patient*

L 518: - *Receive information about the services covered under the hospice benefit*

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Tips for Success

Documentation of advance directive conversation

Review documents for completion

Teach staff to complete all information gained on admission

Checklist for admission elements

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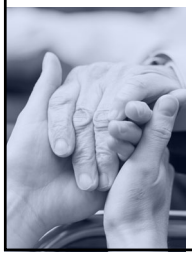

Hospice Assessment, Care Planning and Coordination

HCPC

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Angel Wings Hospice

- Obtained initial accreditation/certification four months ago
- Current census – 30
- Contracting for short term inpatient care and respite services
- Administrator is non-clinical,
- Clinical Director hired last month is new to hospice with Home Health experience

Staff consists of 4 RN case managers, MSW who also fulfills role of volunteer coordinator, Chaplain who also fulfills role of Bereavement Coordinator, 4 hospice aides, Medical Director is contracted

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HCPC 1.I-3.I

Interdisciplinary Group

Composition

- Medical Director
- Registered Nurse
- Social Work
- Pastoral and other counselors

Role

- To provide care and services offered by the organization
- Supervises the care and services provided to the patient and family

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HCPC 4.I-6.I

Hospice Admission Requirements

Initial determination of anticipated life expectancy of six months or less

- Primary terminal condition and related diagnosis(es)
- Current subjective and objective medical findings
- Current medication and treatment orders
- Information about the medical management of any of the patient's conditions unrelated to the terminal illness

Recertification

- Determined by medical director or designated physician
- Timeframe no later than 2 calendar days after first day of each benefit period

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HCPC 7.I-17.I

Timeframes

- Notice of election to be filed within 5 calendar days of the effective date of the election statement

- Initial assessment to be completed within 48 hours of patient's election of hospice care

- Comprehensive assessment to be completed no later than five (5) calendar days after the election of hospice care

- The first day of the five days begins the day after the election

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Scenario

Ms. Iris is being discharged from the hospital with a new diagnosis of stage IV pancreatic cancer with metastasis to the liver and has agreed to hospice care upon returning home. The election was signed by Ms. Iris on 8/30/2021. She arrives home and the hospice team makes plans for assessment and development of the plan of care. Due to staffing circumstances a new employee, an RN new to hospice is scheduled to conduct the assessment. The quality director will be reviewing the documentation post assessment.

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Comprehensive Assessment Elements

Nature and condition causing admission	Co-morbid psychiatric history
Presence or lack of objective data and subjective complaints	Complications and risk factors that may affect care planning
Risk for drug diversion	Functional and cognitive status
Ability to participate in own care	Imminence of death
Symptoms and severity of symptoms	Bowel regimen if opioids are prescribed
Patient and family support systems	Patient/family need for counseling and education
Comprehensive pain assessment	Initial bereavement assessment
Patient/family needs for referrals	Comprehensive drug profile and review
Data elements for outcome measurement	

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HCPC 11.I – HCPC 16.I

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Individual Activity

- Participants will use the assessment in their participant guide on pages 13 to 16 evaluate the abilities of the clinician to conduct a comprehensive assessment individually.
- 4 breakout rooms will be developed into colors yellow, pink, teal, and grey
- The activity will be allowed 15 minutes
- Upon return, the expectation is that everyone will participate in a robust discussion of the positives and challenges of the groups assigned assessment components.

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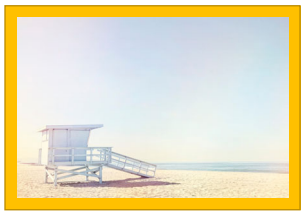
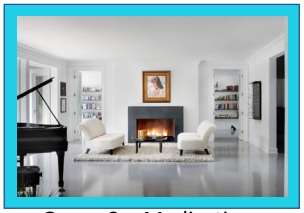
Group Topics



Group One – Vital signs and pain

Group 2 – Psycho-social



Group 3 – Medications and supplies

Group Four – Teaching and Coordination

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Slide 25

BW0 Once the participant guide is ready, put correct dates in
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Slide 26

BW0 Once the participant guide is ready, put correct dates in
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Patient: Iris Wood
SOC: 9/1/2021
Diagnosis – Pancreatic Cancer with metastasis
Secondary – Congestive Heart Failure
Election of benefit signed 8/30/2021
Discharge – Hospital on 8/31/2021
Level of Care: Routine Hospice Care
Age: 70
Advance Directives – Yes

Vital Signs:
Temp – 97.7
Pulse – 88
Resp – 24
BP – 118/68
Pulse oximetry - NA

Pain Assessment
Intensity of 4 current and frequently
Acceptable level to patient is 4
Description of pain – sharp abdominal pain with movement, becomes dull after medication taken.
Current medication effective "usually" "better than before I went into the hospital

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HCPC 12.I – Pain Assessment

History of pain and its treatment,
- pharmacological and non-pharmacological

Standardized pain assessment tool appropriate to
- patient's developmental and cognitive status

Characteristics of the pain, including:
- Location,
- frequency
- Intensity

Impact on usual activities and function (e.g., appetite, sleeping)

Goals for pain management – patient and family

Satisfaction with the current level of pain control.

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Patient's Primary Concern/Goal
Relief of pain and to enjoy her remaining days

Caregiver's primary concern/goal
Patient is free from pain per spouse. Primary caregiver is spouse of 49 years

Neurological status
Patient alert and oriented to person, place and time
No issues with vision, smell, taste
Becomes anxious with increasing pain

Cardiac status
Pulse regular, patient with +2 edema both lower extremities (pedal and ankle)
No complaints of chest pain

Respiratory
Respirations even, slightly labored when patients "catches her breathe" due to pain
Oxygen is in place at 2 liters per minute, nasal cannula
Breath sounds bilateral diminished in bases

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Gastrointestinal
Abdomen distended and firm, patient complains of occasional nausea, last bowel movement three days ago. Patient states this is normal for her. Minimal bowel sounds noted in all quadrants.

Genitourinary
Patient incontinent of urine on occasion. Urine observed to be clear and dark yellow. No complaints of burning or pain with urination. Utilizing urinary pads for incontinence.

Musculoskeletal
Patient able to move all extremities. States "I am feeling weaker and am afraid of falling." Husband assists with transfer to chair and patient walking 15 steps with moderate shortness of breath. Patient not willing to use bedside commode at this point.

Activities of Daily Living
Husband is assisting with cleaning, shopping, cooking and assisting with medication administration. Assists patient with bath using shower chair in the shower. Patient independent in feeding self

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Fall Risk Assessment
Standardized fall risk completed, and patient scored as high risk due to the following factors:

- Over age of 65
- Increased anxiety
- Unable to ambulate independently
- Initial admission to hospice
- Attached equipment in relation to 02

Skin Integrity
Poor turgor, skin slightly jaundiced and dry, warm to touch. No rashes, skin tear right leg upon discharge from hospital

Endocrine
No issues

Coping
Patient coping better with diagnosis but is worried about being a burden for her husband.

Medical supplies
Oxygen in place
Patient needs: hospital bed, walker

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HCDT 9.I – Social Work Assessment

Assessment includes:

- Patient's and the family's adjustment to the terminal illness;
- Social and emotional factors related to the terminal illness;
- Presence or absence of adequate coping mechanisms;
- Family dynamics and communication patterns;
- Financial resources and any constraints;
- Caregiver's ability to function effectively;
- Obstacles and risk factors that may affect compliance
- Family support systems to facilitate end-of-life coping

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Medications
See medication list
Drug review completed and no interactions or side effects noted

Patient Name: Iris Wood Diagnosis: Pancreatic Cancer with liver Metastasis	DOB: 3/23/1952 SOC: 7/22/2021
Crestor 10 mg PO daily	
MS Contin 15 mg every 12 hours	
Ativan 0.5mg PO PRN	
Tylenol 325 mg PO PRN	
Atenolol 25 mg PO daily; hold heart rate <50	
Digoxin .25 mg daily	
Albuterol 2.5mg via nebulizer q 6-hour PRN for shortness of breath/wheezing	
Comfort Kit	
DME	
Walker	
10 L concentrator	
Hospital bed	
Overbed table	
Nebulizer	

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Comprehensive assessment needs:
- Nursing
- Social work
- Spiritual care – refused
- Physician
- Bereavement –

Teaching completed:
- Disease process and signs of disease progression
- Plan of care review
- Safety during ambulation/transfer
- On call number

Coordination:
- Physician call for update on patient and orders obtained
- DME call for hospital bed
- Social Work notified of patient admission and summary given
- Volunteer – unable to provide assistance at this time
- Spiritual counselor – not called as patient refused

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Interdisciplinary Group

HCPC 18.I

Interdisciplinary Group prepares a written plan of care in consultation with the attending physician.

HCPC 19.I

Designated RN member of the IDG ensures coordination of care, continuous assessment of patient and family needs, implementation of the interdisciplinary plan of care

HCPC 20.I

Patient and family receive education and training appropriate to their responsibilities.

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Interdisciplinary Group Involvement

The admitting clinician is conducting the assessment and does not address the initial bereavement assessment during their visit. The interdisciplinary team is informed of the admission on day two following the election of benefit. The spiritual counselor calls the patient on day three and is refused entry as the patient prefers to talk with her priest. An email is sent to the team to inform them of the patient's decision. The admitting clinician is off for three days and by day six following the election of benefit, there has been no initial bereavement assessment.

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Plan of Care Elements

- Plan reflects patient and family goals
- Planned interventions based on assessments
- All services needed for palliation of terminal illness
- Pain and symptom management
- Scope and frequency of services
- Measurable outcomes anticipated
- Drugs and treatments
- Medical supplies and appliances
- Level of patient/representative agreement with the plan
- Level of patient/representative involvement with the plan

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Individual Activity

- Participants will review the Plan of Care in their participant guide on pages 19-20 to evaluate the abilities of the clinician to develop a comprehensive Plan of Care.

- The activity will be allowed 10 minutes
- Discussion will follow related to the comprehensive nature of the plan of care

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Discussion

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Patient Name: Iris Wood	DOB 3/23/1952	SOC Date; 9/1/2021
Level of Care: Routine Hospice Care Primary Hospice Diagnosis: Primary Pancreatic Cancer Secondary Diagnosis: Congestive Heart Failure		Referral physician: Attending physician: Name/Address Hospice Medical Director: Name/Address
Address: 45 Apple Blossom Road, Pineville GA		

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Address: 45 Apple Blossom Road, Pineville GA	
Visit frequency: RN 2w9, MSW 1m3, Chaplain – declined, Hospice Aide 2 w 10	
DNR: Yes/No Advance Directive: Yes/No Medical Power of Attorney (POA)Name: Contact phone number Language Preference: English Equipment: Oxygen concentrator, Portable Oxygen cylinders, hospital bed, overhead table, Shower chair etc. Medical Supplies/Appliances: Depends Special Precautions: Example, fall, oxygen, bleeding Allergies:	

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Problem	Alteration in respiratory status
Intervention	Assess vital signs, Assess respiratory status; Assess adequate oxygen to patient comfort level; Teach oxygen Usage, Teach s/s respiratory infection
Goal	Patient will exhibit adequate oxygenation within 1 week as noted by normal respiratory rate and depth.
PATIENT/FAMILY GOAL:	
Problem	Alteration in Pain Management
Intervention	Teach Pt/PCG appropriate use of pain control medications. Teach use of medications per comfort box; assess effectiveness of medication for pain control; assess availability of pain medications; if opiates are prescribed patient placed on stool softener, teach Pt/PCG s/s to report to agency
Goal	Patient's pain will be managed to patient acceptable level of 4
PATIENT /FAMILY GOAL	
Problem	Alteration in urinary status as evidenced by incontinence
Intervention	Assess skin for potential breakdown; Teach Pt/PCG of need to ensure dry clothing/linen;
Goal	Patient will be free from skin breakdown related to incontinence
PATIENT/FAMILY GOAL	
Problem	Alteration in nutritional status
Intervention	Assess nutritional status of patient; Teach Pt/PCG use of small frequent meals rather than large meals; Teach use of high protein supplements
Goal	Patient will be able to enjoy small amounts of food that are appetizing to her. Nutritional status will assist maintenance of skin integrity.

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PATIENT/FAMILY	
Problem	Alteration in ability to care for personal care needs
Intervention	Assess patient need for assistance with ADL. Teach Pt/PCG measures for safety during transfer and ambulation; Aide to provide care to patient 2 times per week for shower with use of shower chair; shampoo each visit, assist with transfer and ambulation; to inform RN of changes in the patient condition
Goal	Patient's personal care needs will be met safely and effectively.

SPECIFIC PHYSICIAN ORDERS AS FOLLOWS:

OXYGEN 2 LITERS VIA NASAL CANNULA CONTINUOUS.

Foley: Size 14 fr Balloon 5cc to drainage bag PRN Yes /No /prn for urinary retention

Routine comfort pack

Patient/Caregiver participated in plan of care and agree to care being provided.

Date: _____Signed and dated by the following physician. Marcus Welby MD

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HCPC 23 - Coordination

IDG is responsible for directing, coordinating and supervising care

Care and services are provided in accordance with the plan of care

Care and services are based upon all assessments

Sharing of information occurs between all disciplines, in all settings
- Including those under arrangement

Coordination occurs with other non-hospice healthcare providers providing services unrelated to the terminal illness and related conditions

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Top Findings in HCPC

Standard	Content	CMS Tag	% Cited of HCPC
HCPC 21.I	Elements of the Plan of Care	L545, L548	25%
HCPC 15.I	Medication Profile and Drug Review	L530	15%
HCPC 9.I	Assessment within 5 days in accordance with elements of the hospice election statement	L523	13%
HCPC 19.I	Designated RN coordinates care/individualized plan of care in collaboration with physician, patient, primary caregiver	L540, L543	12%
HCPC 22.I	Timely review of the Plan of Care, Revision based on assessment and must note progress	L552, L553	9%

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Top Findings in HCPC

HCPC 21.1; 418.56(c): Content of the Plan of Care

L545 - *Goals and Interventions and services for palliation and management of terminal illness*

L548 - *418.56(c)(3) - Measurable outcomes anticipated from implementing and coordinating the plan of care.*

HCPC 15.I; 418.54(c)(6): Drug profile

L530 -*A review of all the patient's prescription and over the-counter drugs, herbal remedies and other alternative treatments*

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Top Findings in HCPC

HCPC 9.I; 418.54(b); Timeframe for completion of the comprehensive assessment

L523 - *The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care*

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Top Findings in HCPC

HCPC19.I; 418.56(a)(1): Responsible lead

L 540 - *The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care.*

***HCPC 19.I;* 418.56(b) Plan of care**

L543 - All hospice care and services furnished to patients and their families must follow an individualized written plan of care

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Top Findings in HCPC

HCPC 22.I; 418.56(d) : Review of the plan of care

L552 - *The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.*

L553 - *Revised plan of care includes the updated comprehensive assessment*

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Tips for Success

- Focused audits
- Use of Templates
- Standardized processes and documentation
- Educate staff on alternate assessment components
  - Psycho-social
  - Spiritual
  - Bereavement

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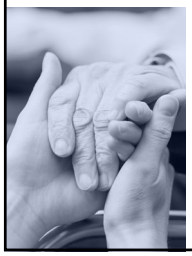
Hospice Care Delivery and Treatment

HCDT



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HCDT Standard Summary

HCDT 1.I-4.I	Provision/Availability of services
HCDT 5.I-14.I	Care in accordance with Plan of Care/standards of Practice
HCDT 15.I-21.I	Aide/Homemaker/Volunteer
HCDT 22.I-28.I	Provision of Services
HCDT 29.I-35.I	Drugs and biologicals
HCDT 36.d-40.I	Discharge/transfer of care
HCDT 41.I	Imminent Death

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Provision of all Services

HCDT.5-12.I

Core Services

- Physician
- Nursing
- Social Work
- Counseling
  - Spiritual
  - Dietary

HCDT.13-21

Non-Core Services

- Physical therapy, Occupational therapy, Speech Language Pathology
- Hospice aide and homemaker services
- Volunteer services

Requirements

- meet the qualifications of their discipline
- Provide services per the plan of care and in compliance with standards of practice
- Under the direction of the physician
- Meet the needs of the patient and family

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Video Discussion

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Interdisciplinary Team Meeting

Review the IDT note from the first meeting held after the visit observed with Ms. Iris (pages 26-27)

Identify areas of challenge for this clinician in her report to the team

Prepare for a robust discussion

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IDT Discussion

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Patient: Iris Wood
SOC: 9/1/2021
Diagnosis – Pancreatic Cancer with metastasis
Secondary – Congestive heart Failure
Level of Care: Routine Hospice Care
Age: 76
Advance Directives – Yes
Opioid usage - yes

Date of Meeting: 10/14/2021

Problem overview:

- diminished respiratory function
- increased weakness
- increased pain
- decreased mobility
- decrease in appetite

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Nursing: Patient pain is increasing and becoming difficult to manage at night. Pain medication changes 3 times this week to gain control to the self-identified level of acceptable pain at 4. Patient restlessness increasing and anxiety level escalating. Increasing loss of appetite, eating only small bites with meals. Increased nausea and lack of bowel movement for past three days. Continues oxygen at 2l/min. Caregiver becoming exhausted and unable to get restful sleep. Patient requiring maximum assistance with transfer. Using walker that husband had in storage from his hip surgery.

Recommendations: continued adjustment of pain medication for control of pain. Continued oxygen for comfort level. Continue aide services at 4 times per week, increase nursing visit to five times per week.
Signed: Nurse Julie RN

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Social Worker: Has not been able to fit patient into her schedule since patient admission.
Recommendations: Social Worker to schedule immediate visit to discuss anxiety and caregiver ability to meet patient needs.
Signed: Socially Adept MSW

Spiritual Counselor: has not seen patient as patient declined services. Not present at this meeting
Recommendations: None

Volunteer Coordinator: has no ability to schedule volunteer
Recommendations: As soon as a volunteer is available, will let the team know to evaluate the need of the patient/family for volunteer services
Signed: Helping Hand

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Physician: Has made multiple changes to medications and will plan on increasing medications as needed and add medication for anxiety.

Recommendations: Orders as follows:

- Social worker will increase visits to weekly with first visit to be within 24 hours
- RN increase visit to 4xw
- No change to aide visits
- Chaplain awaiting patient request
- Volunteer services to be initiated when available
- Adjustments to pain regimen, addition of anxiety med
- Orders for Ensure supplement

Signed: Marcus Welby MD

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Top Findings in HCDT

Standard	Content	CMS Tag	% Cited Of HCDT
HCDT 16.I	Hospice Aide fulfills responsibilities in the plan of care	L 626	29%
HCDT 15.I	Written aide instructions are prepared by RN	L 625	11%
HCDT 39.I	D/C Summary at time of revocation	L 683	10%
HCDT 18.I	Hospice aide reports changes and documents	L 628	8%
HCDT 38.I	Summary needed for transferred patient	L 682	7%

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Top Findings

HCDT.15.I; 418.76(g) : Hospice aide assignments and duties

L625 - Assigned to specific patient by a registered nurse: *Written Instruction*

-Prepared by an RN responsible for the supervision of the aide

- Need to be specific, not generic

HCDT.16

L 626 - A hospice aide provides services:

- Ordered by the Interdisciplinary Group;
- Included in the plan of care;
- Permitted to be performed under state law and regulation;
- Consistent with the hospice aide training.

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Top Findings

HCDT 18.I; 418.76 (g) 4: Hospice Aide

L628 - *Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and/or social needs to a registered nurse as the changes relate to the plan of care and any quality assessment and improvement activities*

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Top Findings

HCDT.38.I; 418.104(e): Discharge or transfer of care

L682 If the care of a **hospice patient is transferred** to a Medicare/Medicaid facility, the hospice forwards to the receiving facility a copy of:

-the hospice discharge summary
-the patient's record, if requested.

Discharge summary includes:
treatments, symptoms, and pain management;

-current plan of care and latest physician orders
-documentation to assist in post-discharge continuity of care

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Top Findings

HCDT.39 I; 418.104(e)(2): Clinical Records

L 682- *If a patient revokes hospice care or is discharged from hospice per hospice regulation §418.26 (i.e., no longer terminally ill), the hospice forwards to the patient's attending physician:*

- A copy of the hospice discharge summary;

- The patient's record, if requested.

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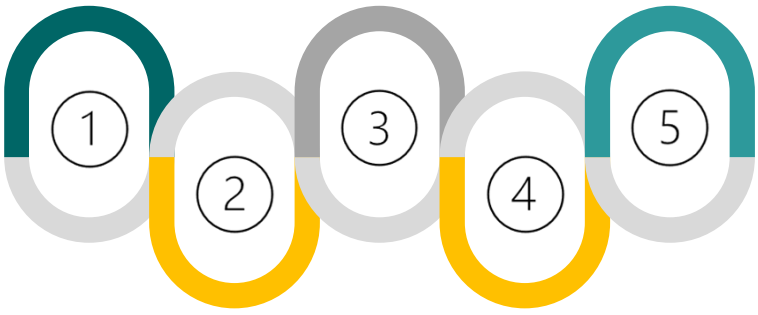
Tips for Success



Policies for remote monitoring

Templates for transfer/discharge

Aide documentation coordinates with the written aide plan of care

Supervisory visits include review of documentation and patient interview

Interdisciplinary team processes
- Addressing absent members
- Ensuring appropriate discussion
- Agenda for meeting
- Documentation template

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Hospice Inpatient Care (HSIC)

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Ms. Iris

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Iris' pain management

Ms. Iris Wood, a 69-year-old female was admitted to the hospice with a terminal diagnosis of Stage 4 pancreatic cancer with metastasis to the lung four weeks ago.

She lives with her husband of 49 years who is somewhat frail but fully involved in her care. The daughter has been providing some assistance but needs to return to her family.

Over a 3-week period, Ms. Iris has had progressive difficulty in pain management. When admitted, the patient's pain was being controlled with Tramadol and the use of Dilaudid 2mg for breakthrough pain, in week two of her hospice episode, her pain medication plan was changed to oxycontin SR every 12 hours with Dilaudid 8mg for breakthrough pain. In week three Fentanyl patches with Actiq lozenges were unable to provide her acceptable relief.

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Thoughts to Consider

Is short-term inpatient care the right choice for Ms. Iris?

What other options could be considered?

What level of care would be appropriate if fatigue of the husband was the main issue?

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Levels of Care

Routine

-90% of care provided; provided in home, ALF; SNF

Continuous

-8-24 hrs/day at home; may include Home Health Aide services

Inpatient Respite

-Caregiver relief, 5 Consecutive days

General Inpatient

Hospice inpatient home or SNF for RN direct 24hr/day care

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GIP Decision

The decision was made to admit her to GIP for pain management. This decision was very difficult for the husband to agree to but after discussion with the social worker, he admitted he felt hopeful in that his wife may be able to get some pain relief. It was noted by members of the IDT that the husband appeared exhausted and had not had a good night's sleep in 3 weeks.

In addition, the personal care needs of his wife were growing more complex each day and without his daughter's help, he was overwhelmed with his wife's needs.

Ms. Iris was admitted to a Medicare Certified Skilled Nursing Facility that the hospice had contracted with for their provision of GIP services.

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Thoughts to Consider

What interventions might need to occur for Ms. Iris to come back home?

Was she admitted to an appropriate facility for the inpatient services?

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HSIC1.–4.I General inpatient standards

- Eligibility
- Pain and symptom management control
- Medicare certified facility

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HSIC 5. Required elements of the written agreement for provision of inpatient care

- Hospice responsibilities
- Facility responsibilities

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Agreement Requirements

Hospice:

- Plan of Care
- Inpatient clinical record
- Discharge summary
- Training
  - Documented
- Compliance

Inpatient Provider:

- Policies
- Clinical Record
- Inpatient record available
- Designated individual

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HSIC 6.I –34.I Direct owned IPU

- Staffing
- Emergency preparedness
- Life Safety Code
- Facility specifics
- Infection control program
- Medication administration

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Specifics to life safety code-LSC

LSC applies to in-patient Hospice facilities

Required to meet NFPA 101 2000 edition of the Life Safety Code

State regulations must meet or exceed the NFPA regulations

LSC requirements for alternate energy sources include:

- A portable and mobile generator meeting LSC NFPA 70 code
- A permanent generator meeting LSC and NFPA guidelines.

LSC requirements for Fire Safety: fire/safety drills are held on all shifts at ***varied*** times

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HSIC 35.I -46.I – Restraint and seclusion

- Use of
- Plan of Care
- Policies and procedures
- Responsible staff
- Training

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Direct or Under Arrangement

Under Arrangement

- Written Agreement
- Ensuring facility complies with Life Safety Code
- Infection control as per hospice policy
- Complies with restraint/seclusion requirements

Direct

- Appropriate staffing/24 Hour Nursing
- Responsible for Emergency Preparedness compliance: policies/testing/communication
- Life Safety Code Compliance
- Facility specific infection control
- Policies related to restraint/seclusion

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Top Findings in HSIC

Standard	Content	CMS Tag	% Cited
HSIC 28.I	Preparation/delivery/storage of meals	L736	38%
HSIC 15.I	Documented/dated Life Safety Code fire drills	E0039, L724 L726	23%

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Top Findings in HSIC

HSIC28.1; 418.110(I) : Meal service and menu planning.

L736 - *Consistent with the patient's plan of care, nutritional needs, and therapeutic diet; (2) Palatable, attractive, and served at the proper temperature; and (3) Obtained, stored, prepared, distributed, and served under sanitary conditions.*

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Top Findings in HSIC

HSIC 15.I; 418.110(c) Physical environment.

L 724 - *The hospice must maintain a safe physical environment free of hazards*

L726 - 418.110(c)(1)(ii): *written disaster preparedness plan in effect for managing the consequences of power failures, natural disasters, and other emergencies*

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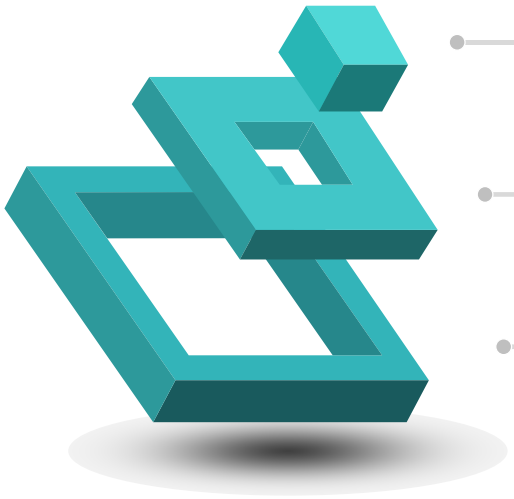
Tips for Success



All agreement elements are present

Review Plan of Care elements

Directly owned
- Plan fire drills
- Mock survey of LSC
- Life Safety Code- QAPI
- Two tests annual of Emergency Plan

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Hospice Care to Residents in a Facility HSRF

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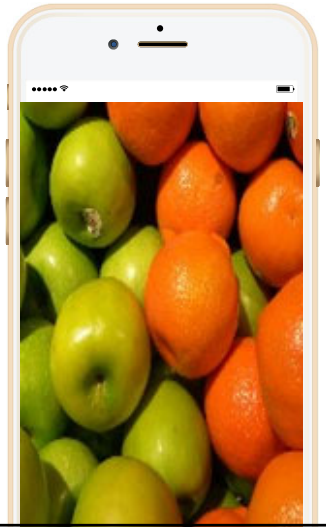
HSIC and HSRF

Similarities

- Written Agreement
- Financial Responsibility.
- Hospice Standards and Plan of Care.



Differences

- Bereavement responsibilities
- Training responsibilities
- Provision of 24-hour nursing

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Hospice Responsibilities

Assessment
Initial and ongoing

Coordination
Interdisciplinary, RN led, Facility staff, arranging for transfers as needed

Care Provision
Professional Staff
Aide Services

Financial Management

Provision of:
Supplies; DME; Medications related to the terminal illness

Determining the Level of Care

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Written Agreement

Hospice Responsibility elements:

The hospice may use the SNF/NF or ICF/IDF nursing staff, where permitted by state law and as specified by the SNF/NF or ICF/IDF, to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family.

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Written Agreement

Hospice Responsibilities elements:

- Medical direction and management of the patient;
- Nursing/Counseling/Social work
- Provision of medical supplies, durable medical equipment, and drugs
- All other hospice services related to terminal illness
- Reporting of mistreatment or abuse
- Provision of bereavement services

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Written Agreement

Facility Responsibility elements:

- 24-hour room and board
- Meeting usual personal care and nursing needs care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home, at the same level of care provided before hospice care was elected by the patient/resident.

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Whose Responsibility

Iris has been admitted to a skilled facility for care following her inpatient stay until her daughter is able to return and provide care for her mother. The hospice will continue to provide care to Ms. Iris in the facility. The RN is explaining to the facility staff the differences in their roles and has decided to provide examples to reinforce their different responsibilities.

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Whose Responsibility?

1. Provision of meals
2. Physician call upon worsening of symptoms
3. Providing a chair bath 3 times per week
4. Assisting with incontinence
5. Determining the bowel regimen
6. Implementing the bowel regimen
7. Determines a need for changing the level of care
8. Financial responsibility for incontinence supplies
9. Financial responsibility for medications addressing the terminal illness

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Yes, or No?

Hospice:

- Calling the physician upon worsening symptoms (2)
- Determining the bowel regimen for a patient on opioids (5)
- Determines a need for changing the level of care (7)
- Financial responsibility for medications addressing the terminal illness (9)

Facility:

- Provision of meals (1)
- Providing a chair bath 3 times per week (3)
- Assisting the patient with incontinence (4)
- Implementing the bowel regimen (6)
- Financial responsibility for long term incontinence supplies (8)

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Top Findings in HSRF

Standard	Content	CMS Tag	% Cited
HSRF 6.I	Hospice plan of care is in place/coordination occurs with facility	L 774	50%
HSRF 9.I	Clinical record required components	L781	50%

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Top Findings in HSRF

HSRF 6.I; 418.112(d)(1): Hospice Plan of Care

L774 - *identify the care and services that are needed and specifically identify which provider is responsible*

***HSRF 9.I :* 418.112(e)(3) Clinical record**

L781 - *must have a process by which information from the hospice IDG plan of care reviews, updated assessments, and the facility team and the patient and family (as applicable) will be exchanged*

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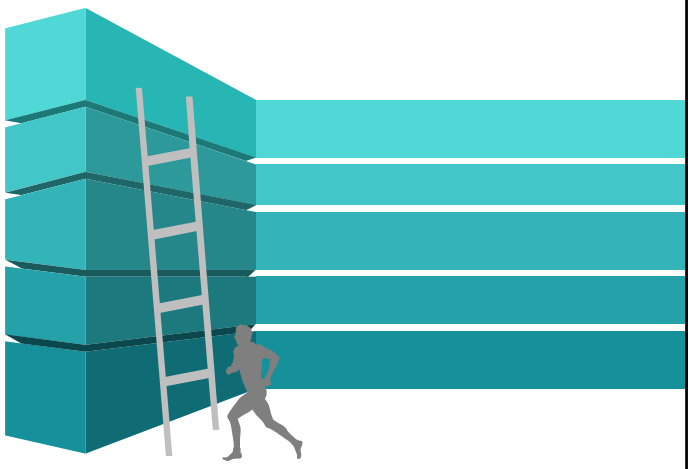
Tips for Success

- Each intervention is assigned
- Documentation reflects coordination and agreement
- Audit record for required hospice elements:
  - Plan of care and other orders
  - CTI
  - Advance directives
  - Contact info for hospice staff
  - 24-hour call direction
  - Hospice medication
  - Hospice physician and attending physician



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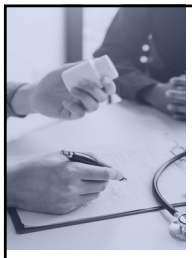
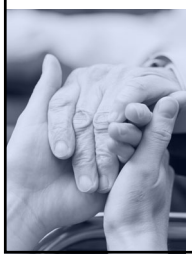


Hospice Leadership and Governance

HSLG



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HSLG Standard Summary

HSLG 14 – 16 agreements
HSLG 17-18 Multiple locations

HSLG 1 – compliance with local, state, federal and licensed as required

HSLG 7 - Volunteers

HSLG 9-13 DME, Drugs Biological

HSLG 2 - HSLG4 – governance and leadership

HSLG 5 -6 Financial Management

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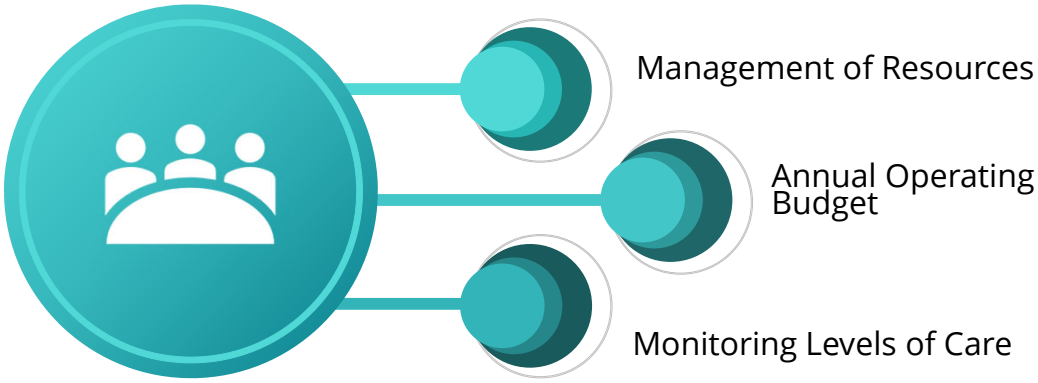
Organizational Operations



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Governance

- Appointing of administrator
- Overall management and operation
- Provision of care and services
  - Leadership
  - Core
  - Non-Core
  - Volunteers
- Fiscal operations
  - Annual operating budget
  - Use of inpatient days
- Ongoing performance improvement

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Administrator

Appointed by the governing body
- Hospice employee
- Meets qualifications required by the governing body

Reports to the governing body

Responsible for day-to-day operations

An alternate is to be identified to address the duties of the administrator when not available

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Fiscal Operations

Resources are managed to enable the ability to meet the palliation needs of the patient and management of the terminal illness

Operating budget
- Reflects scope and complexity of service provided
- Includes projected revenue and expense

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Volunteers

- Day to day administrative
- Direct patient care
- Time equals 5% of total patient care hours
- Cost savings is document
- Documentation:
  - Position held by volunteer
  - Work time spent by volunteer
  - Dollar estimate if same time spent by paid employee

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DME

Is **safe** and in working order

- Manufacturer's guidelines are followed for routine and preventive maintenance
- Repair and maintenance policies are developed when the manufacturers guidelines for a piece of equipment do not exist

Persons under **contract** may be used to ensure **maintenance** and repair of durable medical equipment

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Drugs and Biologicals

Are obtained from community or institutional pharmacists or stocks the drugs and biologicals itself

Discrepancies related to controlled medications

- are investigated immediately by the pharmacist and Hospice administrator
- are reported to the appropriate state authority
- a written account of the investigation is available to state and federal officials

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Agreements

- Scope of services
- IDG oversight and coordination
- Communication
- Care authorized by hospice
- Qualified personnel
- Safe and effective care
- In accordance with Plan of Care
- Hospice may contract with medical director services
  - Self employed physician
  - Physician employed by professional entity or physician group

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Multiple Locations

- Complies with federal regulation regarding disclosure of ownership and control information
- Ensures hospice multiple locations are approved by Medicare
- Ensures that each location is licensed in accordance with state licensure laws
- Clearly delineates lines of authority
- Shares administration

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Top Finding in HSLG

Standard	Content	CMS Tag	% Cited HSLG
HSLG 3.I	Administrator qualifications and alternate	L 651	43%

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Top Finding

HSLG.3.I; 418.100(b): Governing body and administrator

L651 - A governing body assumes full legal authority and responsibility for the management of the hospice, all services, fiscal operations, quality.

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Tips for Success

- Oversight of volunteer program
- Schedule annual meetings
- Audit agreements for verbiage and compliance with the elements

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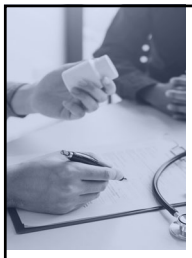
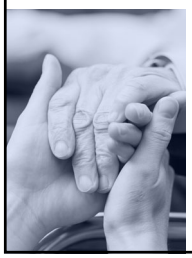


Hospice Information Management

HSIM



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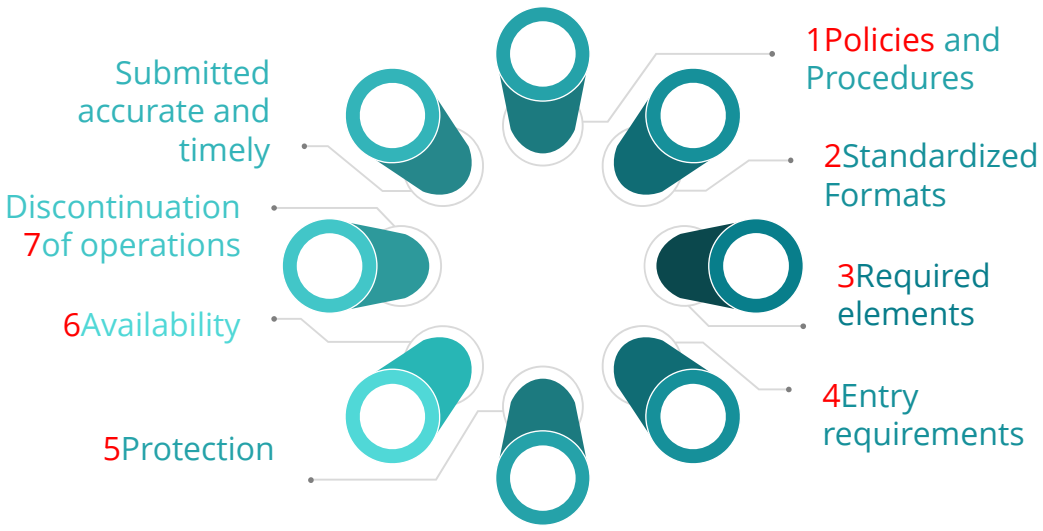
Resource Tool Summary



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Clinical Record Elements

•Plans of Care
- Assessments
- Clinical notes
- Patient rights
- Hospice Election of Benefit
- Responses to interventions

•Outcome measure data elements
- Physician certification
- Advance Directives
- Inpatient discharge summary
- Physician orders

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Election of Benefit

Information to be provided to the patient

- Hospice Philosophy
- Effects of a Medicare Hospice Election
- Financial responsibility
- Notice of Hospice non-covered Items
- Right to choose attending physician
- Acceptance of Hospice Medicare Coverage

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Notification of Non-Covered Items

- ✓ Diagnosis related to terminal illness and related conditions
- ✓ Diagnosis unrelated to terminal illness and related conditions
- ✓ Non-Covered items, services and drugs determined by hospice as not related to terminal illness and related conditions

https://www.cms.gov/files/document/model-hospice-election-statement-and-addendum.pdf

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Certification of Terminal Illness

Timeframe
Verbal or written no later than 2 calendar days after the start of each benefit period.

- Written must be signed and dated prior to billing Medicare

Initial certification and recertifications may be completed up to 15 days prior to the start of the next benefit period

Certifying Physician only

Contents

- •Medical prognosis
- •Narrative
- •The benefit period dates

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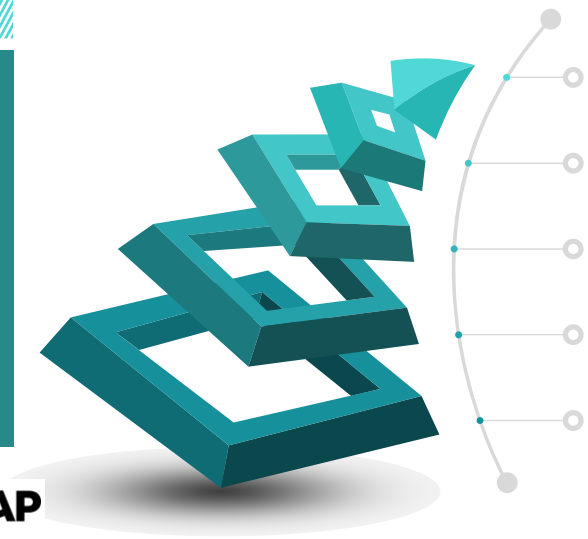
Narrative



- Written by the certifying physician
- Clinical findings that support six months or less life expectancy
- If part of the form, above the physician's signature.
- If an addendum, signature follows the narrative.
- The physician attests by signing, the narrative was composed based on review of the patient's medical record or his/her examination of the patient.

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Face to Face Encounter

Third benefit period and subsequent:

- Why clinical findings of face-to-face encounter support six months or less.
- Documentation
  - date of the encounter,
  - an attestation by the physician or nurse practitioner that he/she had an encounter with the beneficiary.
    - If the encounter was done by a nurse practitioner, he/she must attest that clinical findings were provided to the certifying physician

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Common Errors

Narrative
- missing
- No attestation statement

Verbal Certification
- If applicable, missing one or both the Medical Director and/or attending

Signature and date
- No physician signature
- Illegible signature
- Predating physician signature
- Signature not dated
- Lack of both Medical Director and Attending signatures as applicable

Certification Dates
- Not clearly stated

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Top Finding in HSIM

Standard	Content	CMS Tag	% Cited
HSIM 3.I	Elements of the clinical record	L 676, L 673, L 678	95%

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Top Finding in HSIM

HSIM 3.I; 418.104(a)(5) Clinical Records

L 676 - *Physician certification and recertification of terminal illness*

L673 - 418.104(a)(2) - *Signed copies of the notice of patient rights and election statement*

L678 - 418.104(a)(7) - *Physician orders*

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Tips for Success

- Checklist for Election of Benefit and Certificate of Terminal Illness
- Quality review of record components
- Audit of EOB and CTI before billing
- Education of staff ongoing

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