CHAP

Hospice Accreditation Intensive
for Organizations & Consultants

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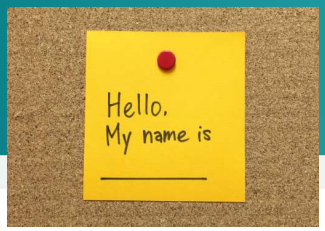
Housekeeping Items



Introductions

Agenda
&
Handouts

Microsoft Teams

Teams Use
- Muting
- Use of Chat
- Raise of Hand
- Reactions

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Small Groups

- Name
- State
- Why Hospice
- Fun Fact

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- How many years has your organization been in existence?
  - Not yet accepting patients
  - 1-5 years
  - 6-10 years
  - 11-15 years
  - 16-20 years
  - Over 20 years
- How long have you been in the hospice industry?
  - Less than 1 year
  - 1-5 years
  - 6-10 years
  - 11-15 years
  - 16-20 years
  - Over 20 years
- Are you familiar with the CHAP Hospice Standards of Excellence?
  - Yes
  - No

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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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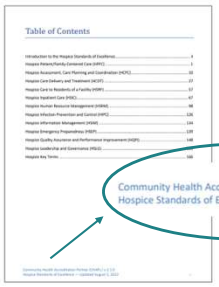
Revisions

Revision Reference Table

In response to the *Medicare and Medicaid Programs; Policy and Regulatory Changes to the Omnibus COVID-19 Health Care Staff Vaccination Requirements Final Rule (CMS-3415-F)*, the following revisions were approved by CMS.

Standard	Summary	Effective Date
HIPC 11	Removed	8/5/2023
HIPC 12	Removed	8/5/2023
HIPC 13	Removed	8/5/2023
HIPC 14	Removed	8/5/2023
HIPC 15	Removed	8/5/2023
HIPC 16	Removed	8/5/2023
HIPC 17	Removed	8/5/2023
HIPC 18	Removed	8/5/2023

Version



Evidence Guidelines

Standards	Evidence Guidelines
HPFC 1.D The hospice has a written Patient Bill of Rights and Responsibilities (Bill of Rights). The patient has the right to be informed of their rights and responsibilities, and the hospice defines, protects, and promotes the exercise of these rights. Applicable Regulations: L500-418.52.	**Document Review:** Validate the agency has a Patient Bill of Rights prepared. **Clinical Record Review:** Confirm that there is a written statement of the Patient Bill of Rights provided to patients.

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Hospice
Standards of Excellence

CHAP Education

Hospice Standards
CHAP Inc.

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Key Performance Areas

The Hospice Standards of Excellence are organized into one of the following Key Performance Areas.

Patient Centered Care

Patient/Family-Centered Care

Assessment, Care Planning & Coordination

Care Delivery & Treatment

Safe Care Delivery

Inpatient Care

Infection Prevention & Control

Emergency Preparedness

Sustainable Organizational Structure

Human Resource Management

Information Management

Quality Assurance & Performance Improvement

Leadership & Governance

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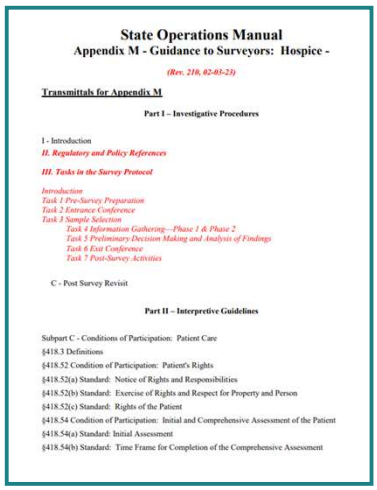
Additional Resources:
State Operations Manual



State Operations Manual
Appendix M - Guidance to Surveyors: Hospice -

(Rev. 210, 02-03-23)

Transmittals for Appendix M

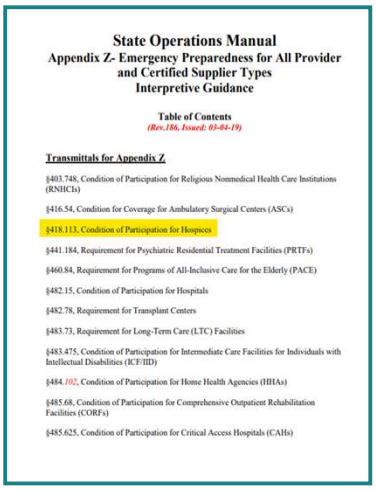
Part I – Investigative Procedures

I - Introduction
II. Regulatory and Policy References
III. Tasks in the Survey Protocol
Introduction
Task 1 Pre-Survey Preparation
Task 2 Entrance Conference
Task 3 Sample Selection
Task 4 Information Gathering—Phase 1 & Phase 2
Task 5 Preliminary Decision Making and Analysis of Findings
Task 6 Exit Conference
Task 7 Post-Survey Activities

C - Post Survey Revisit

Part II – Interpretive Guidelines

Subpart C - Conditions of Participation: Patient Care
§418.3 Definitions
§418.52 Condition of Participation: Patient's Rights
§418.52(a) Standard: Notice of Rights and Responsibilities
§418.52(b) Standard: Exercise of Rights and Respect for Property and Person
§418.52(c) Standard: Rights of the Patient
§418.54 Condition of Participation: Initial and Comprehensive Assessment of the Patient
§418.54(a) Standard: Initial Assessment
§418.54(b) Standard: Time Frame for Completion of the Comprehensive Assessment



State Operations Manual
Appendix Z- Emergency Preparedness for All Provider and Certified Supplier Types
Interpretive Guidance

Table of Contents
(Rev.186, Issued: 03-04-19)

Transmittals for Appendix Z

§403.748, Condition of Participation for Religious Nonmedical Health Care Institutions (RNHCIs)
§416.54, Condition for Coverage for Ambulatory Surgical Centers (ASCs)
§418.113, Condition of Participation for Hospices
§441.184, Requirement for Psychiatric Residential Treatment Facilities (PRTFs)
§460.84, Requirement for Programs of All-Inclusive Care for the Elderly (PACE)
§482.15, Condition of Participation for Hospitals
§482.78, Requirement for Transplant Centers
§483.73, Requirement for Long-Term Care (LTC) Facilities
§483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
§484.*102*, Condition of Participation for Home Health Agencies (HHAs)
§485.68, Condition of Participation for Comprehensive Outpatient Rehabilitation Facilities (CORFs)
§485.625, Condition of Participation for Critical Access Hospitals (CAHs)

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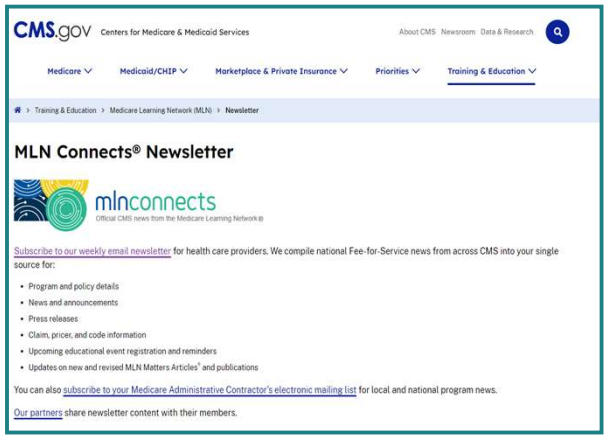
Additional Resources:
MLN Connects & CHAP eNews



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MLN Connects® Newsletter | CMS

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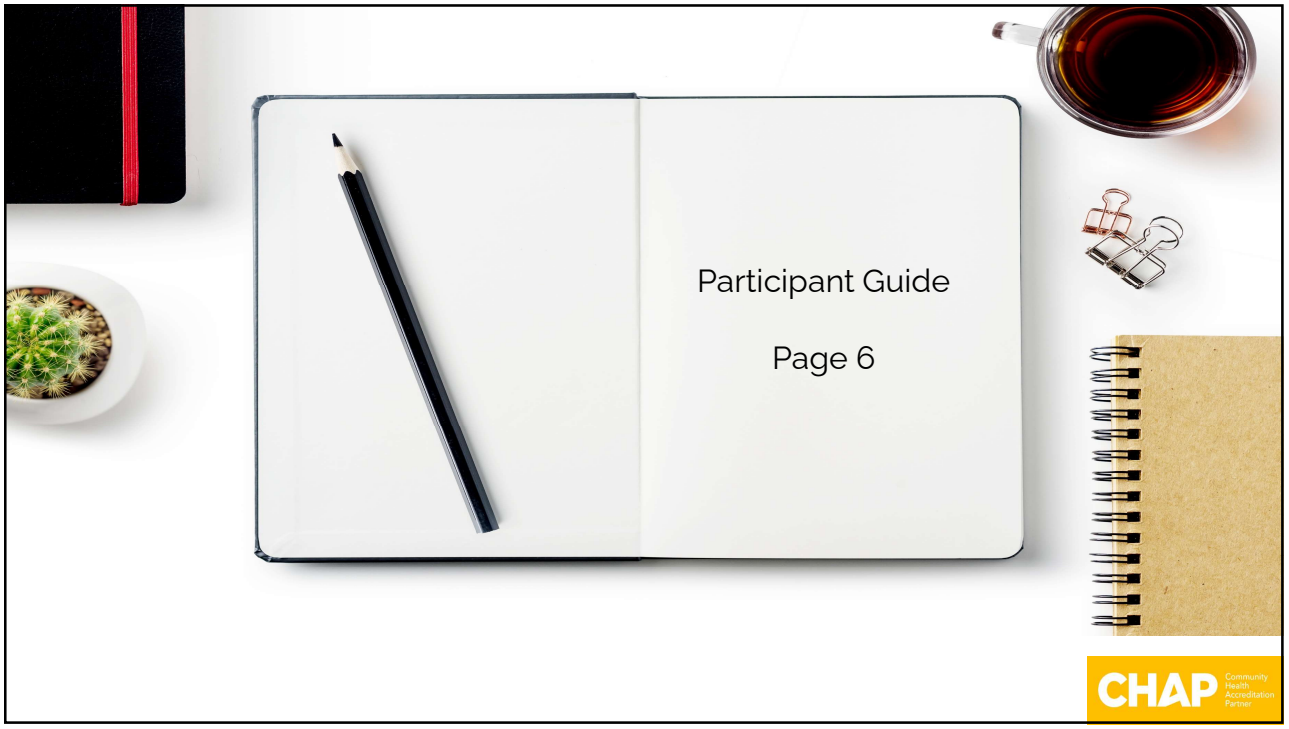

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Hospice Patient/Family-Centered Care (HPFC)

KEY PERFORMANCE AREA

An Interdisciplinary Group (IDG) engages with patients and families at home and in their community to ensure that the care and services provided respect and respond to individual preferences and goals of terminally ill individuals and the needs of their families.

The patient defines "family" and "caregivers."

The hospice defines and protects patient and family rights in the delivery of care in the home and community.

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HPFC Standard Summary

Patient Rights

***HPFC 1.D**
Written Patient Bill of Rights

***IHPFC 2.D**
Bill of Rights Elements

***HPFC 3.I**
Provide verbal and written Bill of Rights and obtain signature

HPFC 6.D
Complaint process defined

HPFC 7.D
Report abuse

HPFC 8.D
Respond to alleged violations

***HPFC 9.D**
Advanced Directive Policy

***HPFC 10.I**
Provide information on Advanced Directives

* Included in top 2022 findings

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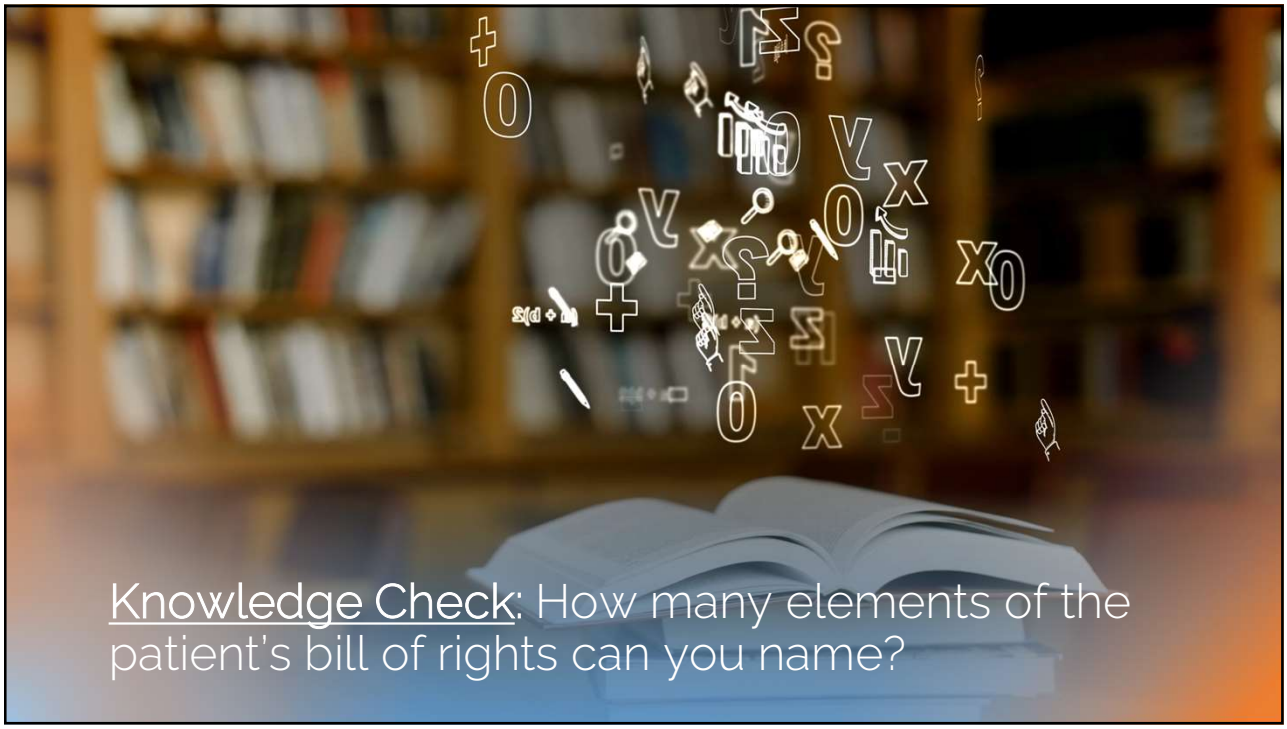

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Elements of the Patients' Bill of Rights
HPFC 2.D

- Be involved in plan of care development
- Be informed about the scope of services
- Refuse care or treatment
- Receive effective pain management

- **Choose their attending physician**
- Be free from mistreatment, neglect, or verbal, mental, sexual, or physical abuse, including injuries of unknown source, and the misappropriation of patient property

- Have person and property treated with respect
- Voice grievances without fear of reprisal
- Be informed and receive written information on the hospice's policy on advanced directives

- Have a confidential record
- Receive information about the services covered under the hospice benefit

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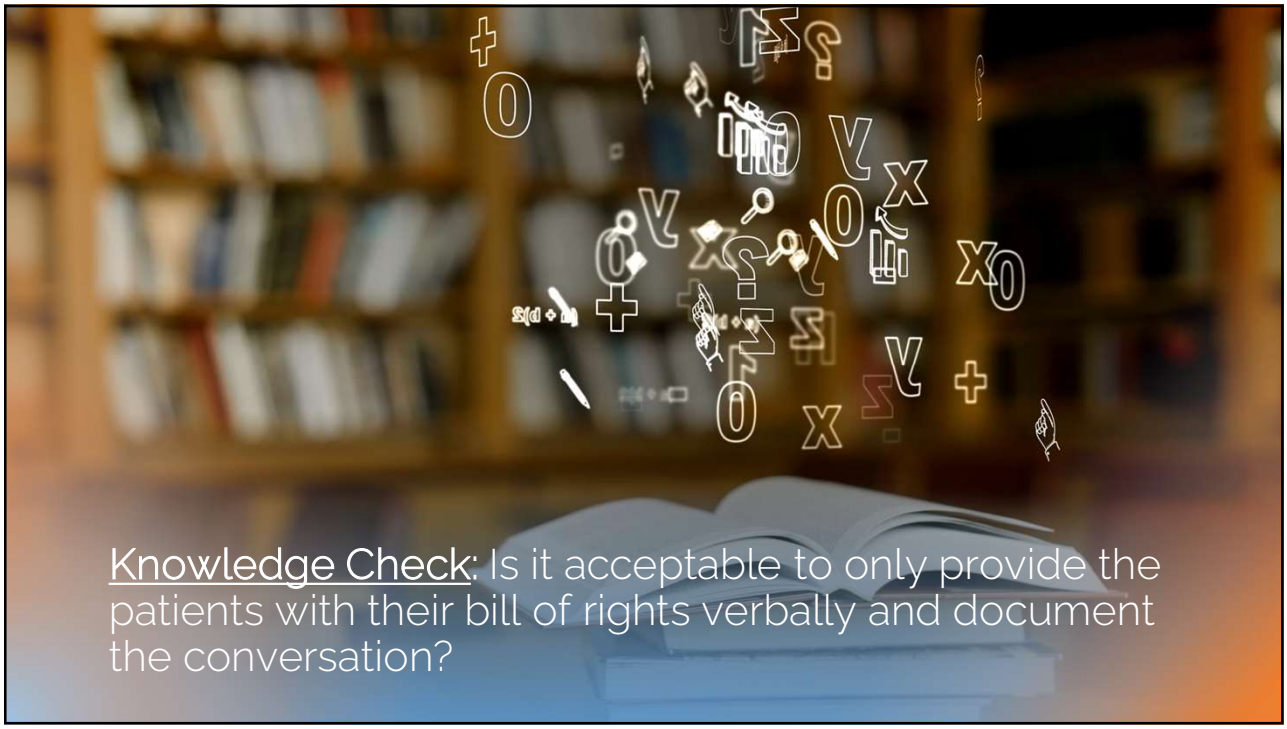

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During the initial assessment visit and in advance of providing care:

The hospice provides the patient—or their representative—with verbal and written notice of the patient's rights and Responsibilities.

This information is provided in a language and manner that the patient understands.

HPFC 3.I

The hospice obtains the patient's or representative's signature confirming that they received a copy of the Bill of Rights and Responsibilities statement.

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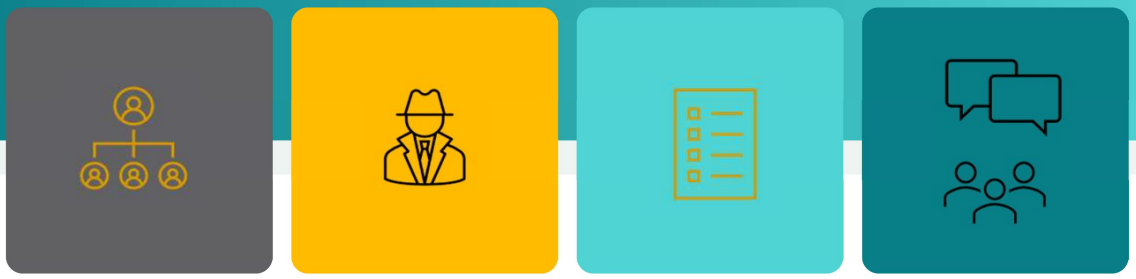
Complaint/Grievance Management Process HPFC 6.D

Policy & Procedure defines the process and includes…



Designation of staff responsible for managing the complaint process

Procedures and timeframes for documented intake and investigation

Documented status of the complaint, including resolution

Corrective action taken & information shared with complainant.

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Bill of Rights

HPFC 1.D

Advanced Directives

HPFC 9.D & HPFC 10.I

- The hospice has a written Patient Bill of Rights and Responsibilities (Bill of Rights).
- The hospice informs and distributes to the patient written information about its policies on advance directives, including a description of applicable state law.
- The hospice provides information on advance directives upon initiation of hospice care.

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2022 Top HPFC Findings

Standard	Content	CMS Tag
HPFC 2.D	Elements to be present in the Patient Bill or Rights (26%)	L515, L503, L518
HPFC 9.D	Advance directive written information elements (19%)	L503
HPFC 1.D	Hospice has a patient bill of rights (16%)	L501
HPFC 10.I	Advance directive provided to patients (16%)	L503
HPFC 3.I	Bill of rights is provided verbally and in writing prior to provision of care. Signature is obtained. (16%)	L504

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HPFC 2.D

Elements of the Patient Bill of Rights & Associated L Tags

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.

L515
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.

L518
Receive information about the services covered under the hospice benefit

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Tips for Success

Documentation of an advanced directive conversation

Teach staff to complete all information obtained on admission

Review documentation for completion

Develop a checklist for admission elements

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Patient MRN	Complaint
465382	The patient's husband called and stated they haven't seen or heard from their social worker in almost 2 months.
465932	The daughter of the patient called to state that when she pulled up to her mother's house the hospice aide was standing on the driveway finishing her cigarette and she watched her flick it to the street curb prior to entering the house.
465962	The patient called complaining that when her hospice aide is giving her a bed bath, she is rough and last time she was there she was so rough she caused a skin tear to her left shin.
457363	The patient's son reported to his mother's nurse that the Chaplain never arrives when he says he will arrive, and it throws off his mother's routine.

Complaint Handling Discussion

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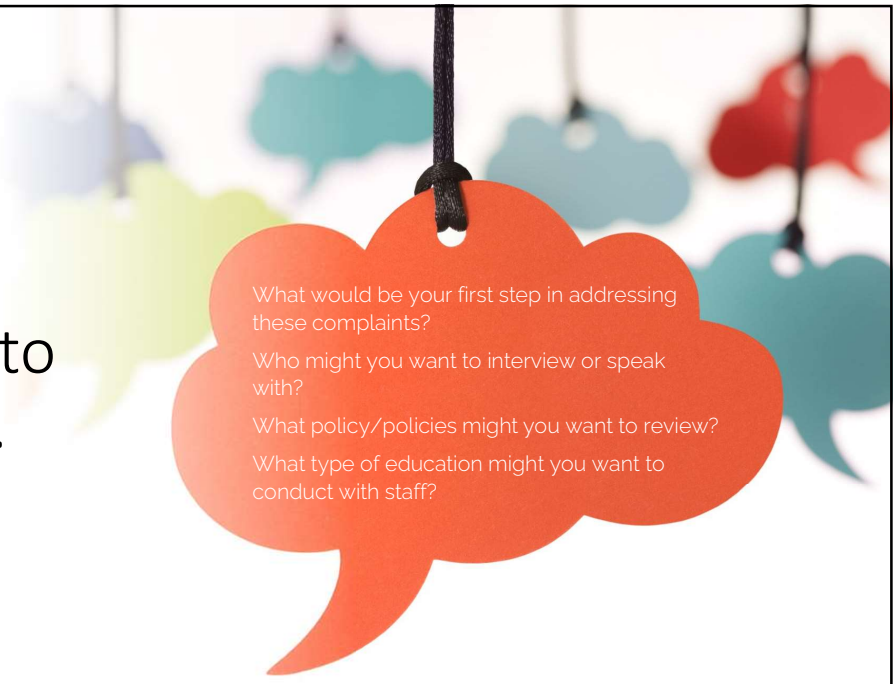
Thoughts to consider…



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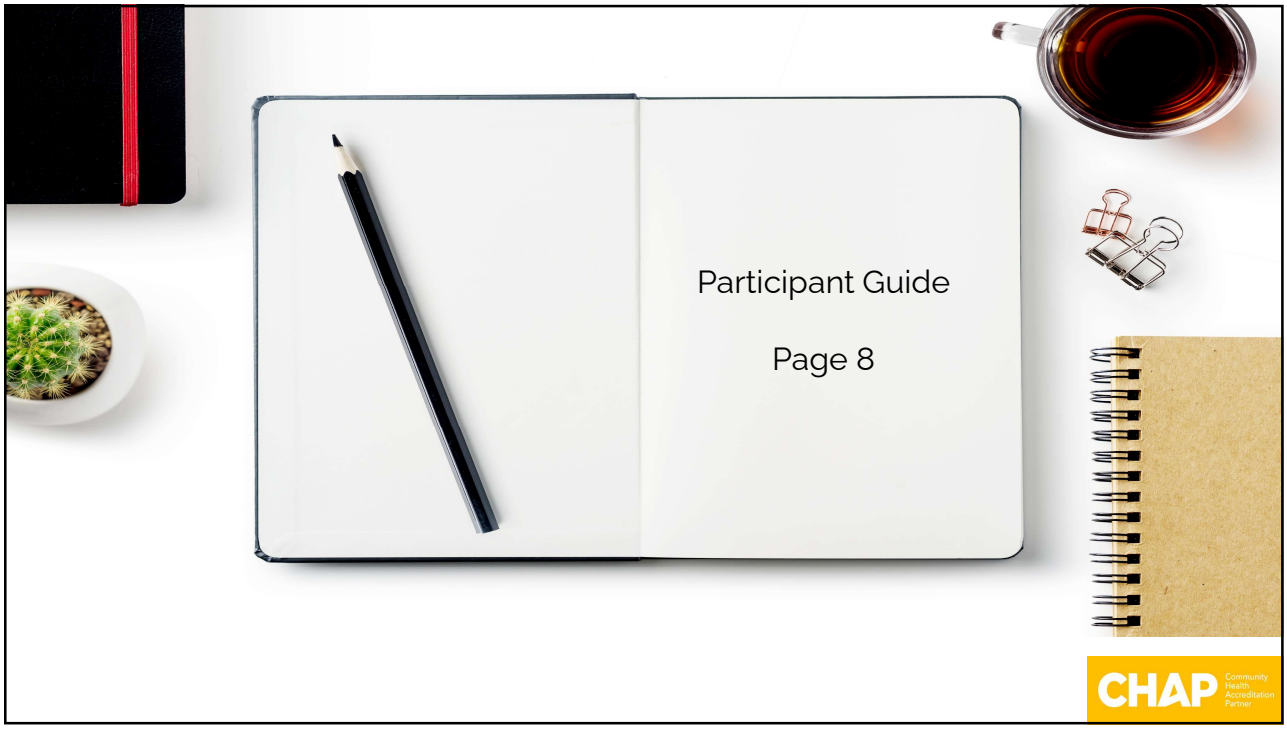

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Hospice Assessment, Care Planning and Coordination (HCPC)

KEY PERFORMANCE AREA

Interdisciplinary Group (IDG) members use effective communication to:

Facilitate ongoing assessment of patient and family needs;

Develop and implement a care plan that represents the patient's goals and preferences;

Support effective coordination of care.

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HCPC Standard Summary

HCPC 1.I & HCPC 2.D

IDG

HCPC 4.I & HCPC 6.I

Initial Certification & Recertification

HCPC 18.I & 19.I
HCPC 21.I & 22.I

Plan of Care

HCPC 7.I – HCPC 17.I

Initial & Comprehensive Assessment

HCPC 20.I

Education to Patient/Family

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Interdisciplinary Group HCPC 1.I – HCPC 3.I

- Doctor of Medicine or Osteopathy (who is an employee or under contract with the hospice)
- Registered Nurse
- Social Worker
- Pastoral or other counselor

The team works together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the patient/family facing terminal illness and bereavement.

- IDG members provide the care and services offered by the organization.
- The IDG, in its entirety, supervises the care and services provided to the patient and family.

If the hospice has more than one Interdisciplinary Group, a designated IDG establishes policies governing the day-to-day provision of hospice care and services.

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Hospice Admission Requirements
HCPC 4.I

The hospice medical director or physician designee reviews the clinical information for each patient being evaluated for admission and provides written certification that it is anticipated that the patient's life expectancy is six months or less if the illness runs its normal course.

Hospice Recertification
HCPC 6.I

The hospice medical director or physician-designee provides written and signed recertification of the terminal illness to meet the hospice care benefit requirement.

The following is considered…

The primary terminal condition;

Related diagnosis(es), if any;

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

For recert…

Recertification is determined by the medical director or physician designee's review of patient clinical information;

Recertification is completed no later than two (2) calendar days after the first day of each benefit period, and no more than fifteen (15) days before the next benefit period begins.

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HCPC 5.I

The hospice notifies the referral source when hospice care cannot be provided.

What occurs if your organization cannot accept the referral?

What reasons have you had for not accepting a referral?

Do you have a relationship with another hospice agency to accept patients?

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The Comprehensive Assessment

HCPC 7.I
The hospice conducts and documents a **patient specific comprehensive assessment** that identifies the patient's need for hospice care and services, and the patient's need for **physical, psychosocial, emotional, and spiritual care.**

The assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.

HCPC 10.I
The comprehensive assessment identifies the physical, psychosocial, emotional, and spiritual needs related to the patient's terminal illness that are addressed to promote the patient's:
1. Well-being;
2. Comfort;
3. Dignity throughout the dying process.

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Assessment Elements
Nature and condition causing admission
Presence or lack of objective data and subjective complaints
Risk for drug diversion
Ability to participate in own care
Symptoms and severity of symptoms
Patient and family support systems
Comprehensive pain assessment
Patient/family needs for referrals
Data elements for outcome measurement

HCPC 11.I
through
HCPC 16.I

Assessment Elements
Co-morbid psychiatric history
Complications and risk factors that may affect care planning
Functional and cognitive status
Imminence of death
Bowel regimen if opioids are prescribed
Patient/family need for counseling and education
Initial bereavement assessment
Comprehensive drug profile and review

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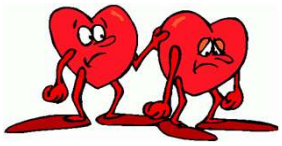
Initial Bereavement Assessment

HCPC 13.I
The comprehensive assessment includes an initial bereavement assessment of the needs of the patient's family and other individuals, focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death.

Information gathered from the initial bereavement assessment is incorporated into the plan of care and considered in the bereavement plan of care.



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Timeframes

HCPC 8.1

RN completes an initial assessment within 48 hours of the patient's election of hospice care.

48 Hours

5 Days

HCPC 9.1

The IDG completes an initial comprehensive assessment no later than five (5) calendar days after the election of hospice care.

HCPC 17.1

Update of the comprehensive assessment is completed by the IDG every 15 days.

15 Days

5 Calendar Days

An aside…Notice of Election (NOE)

NOE must be filed within 5 calendar days after the effective date of the election statement.

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Ms. Iris' hospice journey…

Ms. Iris is being discharged from the hospital to home with initial hospice care. Her primary diagnosis is stage IV pancreatic cancer with liver metastasis. Her primary caregiver is her husband of 50 years who is struggling with COPD. The next closest relative is a daughter living 500 miles away. Both Ms. Iris and her husband are very anxious about this next step. Due to staffing circumstances a new employee, an RN new to hospice is scheduled to conduct the assessment. As the consultant/Administrator, you are evaluating the admission documentation and process.

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Group Activity – 15 mins

Attendees will be divided into five breakout rooms
Each participant should conduct a high-level overview of the entire assessment.

Assessment on Pages 9-12

Each group addresses their assigned task
Evaluate what was documented
Make suggestions for improvement

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Individual Groups

Each group will be assigned key elements of the assessment for in-depth review.

Group 1 – focus on **vital signs and pain assessment**
Group 2 – focus on **psychosocial aspects**
Group 3 – focus on **functional aspects**
Group 4 – focus on **medications**
Group 5 – focus on **coordination aspects**

Each group assigns one spokesperson to share the thoughts from the group.

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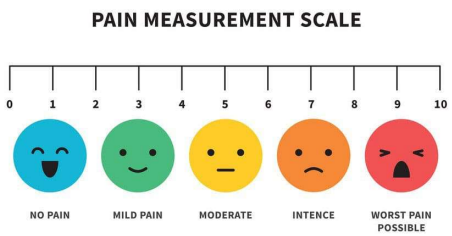
Pain Assessment

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
Assessment of the Patient's Pain

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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Psychosocial Assessment

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 50 years

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

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

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

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HCDT 9.I
Psychosocial Assessment

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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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

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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Medications

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

HCPC 15.I
Medication Review Process & Drug Profile

The documented comprehensive assessment includes a drug profile that contains the patient's current:
- Prescription and over-the-counter (OTC) drugs; Supplements;
- Herbal remedies;
- Other alternative treatments that could affect drug therapy.

The medication review process includes the identification of the following:
- The effectiveness of drug therapy;
- Drug side effects;
- Actual or potential drug interactions;
- Duplicate drug therapy;
- Drug therapy

The drug profile is updated per the hospice policy and procedure, but, at minimum, at the time of each comprehensive assessment and/or when new medication is added, or changes are made to existing medication.

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Medication List

Patient Name: Iris Wood Diagnosis: Pancreatic Cancer with liver Metastasis	DOB: 3/23/1952 SOC: 7/22/2021
Medications	
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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Coordination

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- Physician call for update on patient and orders obtained
- DME call for hospital bed and walker
- Social Worker notified of patient admission and summary given
- Spiritual Counselor was refused Volunteer unable to provide assistance at this time

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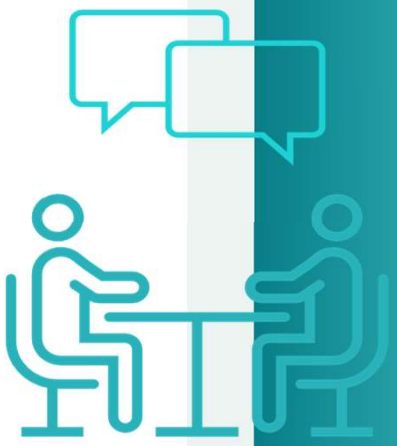

Coordination of Care

HCPC 23.D

The hospice's policies and procedures define a system of communication and integration that sustains **coordination of services and provides documentation of exchange of information**.

The policies and procedures ensure that:

- The Interdisciplinary Group maintains responsibility for directing, **coordinating**, and supervising the care and services provided
- Care and services provided are in accordance with the plan of care
- Care and services provided are based on all assessments of the patient and family needs
- **Sharing of information occurs between all disciplines providing care and services in all settings** and is ongoing whether or not the care and services are provided directly or under arrangement
- **Sharing of information occurs and is ongoing with other non-hospice healthcare providers** providing services unrelated to the terminal illness and related conditions

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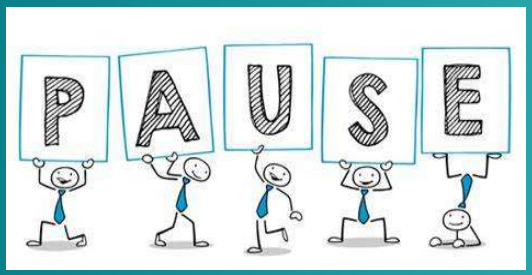

Pause and Consider…

Based on the assessment information provided, the admitting RN did not conduct the initial bereavement assessment during their visit. The spiritual counselor was refused as the patient prefers to talk with her priest. The interdisciplinary team was informed of the admission on day two following the election of benefit. The social worker called on day two and the family requested a visit for next week. By day six following the election of benefit, there has been no initial bereavement assessment completed.

Is this a compliance issue?

If so, what is the issue?

How could this issue have been handled differently to ensure compliance with the standard?

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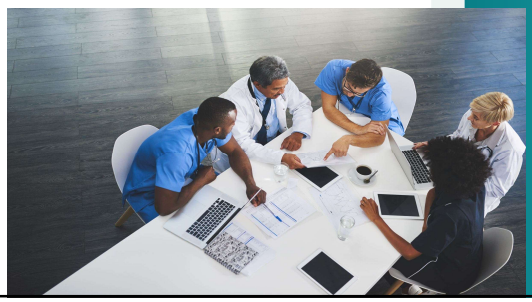
Hospice Interdisciplinary Group

HCPC 18.1
The hospice designates an **Interdisciplinary Group** or groups who, in consultation with the patient's attending physician, **prepare a written plan of care** (POC) for each patient.

The plan of care specifies the hospice care and services necessary to meet the specific needs of the patient and family identified in the comprehensive assessment, relative to the terminal illness and associated conditions



HCPC 19.1
The hospice designates a registered nurse member of the IDG to:

- Provide coordination of care
- Ensure continuous assessment of each patient's and family's needs
- Ensure the implementation of the interdisciplinary plan of care

Hospice care and services provided to patients and families follow the individualized plan of care established by:

- The hospice IDG in collaboration with the attending physician (if any)
- The patient or patient representative
- The primary caregiver in accordance with the patient's needs

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Plan of Care
HCPC 21.I

Each patient's individualized written plan of care:

- 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

Plan of Care Updates
HCPC 22.I

The Interdisciplinary Group, in collaboration with the individual's attending physician (if any), reviews, revises, and documents the individualized care plan:

- As frequently as the patient's condition requires; but…
- No less frequently than **every 15 calendar days**

A revised plan of care includes:

- Information from the patient's updated comprehensive assessment
- Record of the patient's progress toward the outcomes and goals specified in the plan of care

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Patient & Family Education
HCPC 20.I

The hospice ensures that each patient and the primary caregiver(s) receive education and training, provided by the hospice, as appropriate to their responsibilities for care as stated in the plan of care.

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Individual Activity

- Review the Plan of Care in your participant guide on pages 13-14 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

Discussion…

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2022 Top HCPC Findings

Standard	Content	CMS Tag
HCPC 21.I	Elements of the Plan of Care (25%)	L545, L548
HCPC 15.I	Medication Profile and Drug Review (18%)	L530
HCPC 9.I	Assessment within 5 days in accordance with elements of the hospice election statement (13%)	L523
HCPC 19.I	Designated RN coordinates care/individualized plan of care in collaboration with physician, patient, primary caregiver (13%)	L540, L543
HCPC 18.I	Interdisciplinary Group in consultation with the physician develop the written plan of care (7%)	L538

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Tips for Success

Focused Audits

Use of templates

Standardized processes and documentation

Education staff on assessment components and plan of care development

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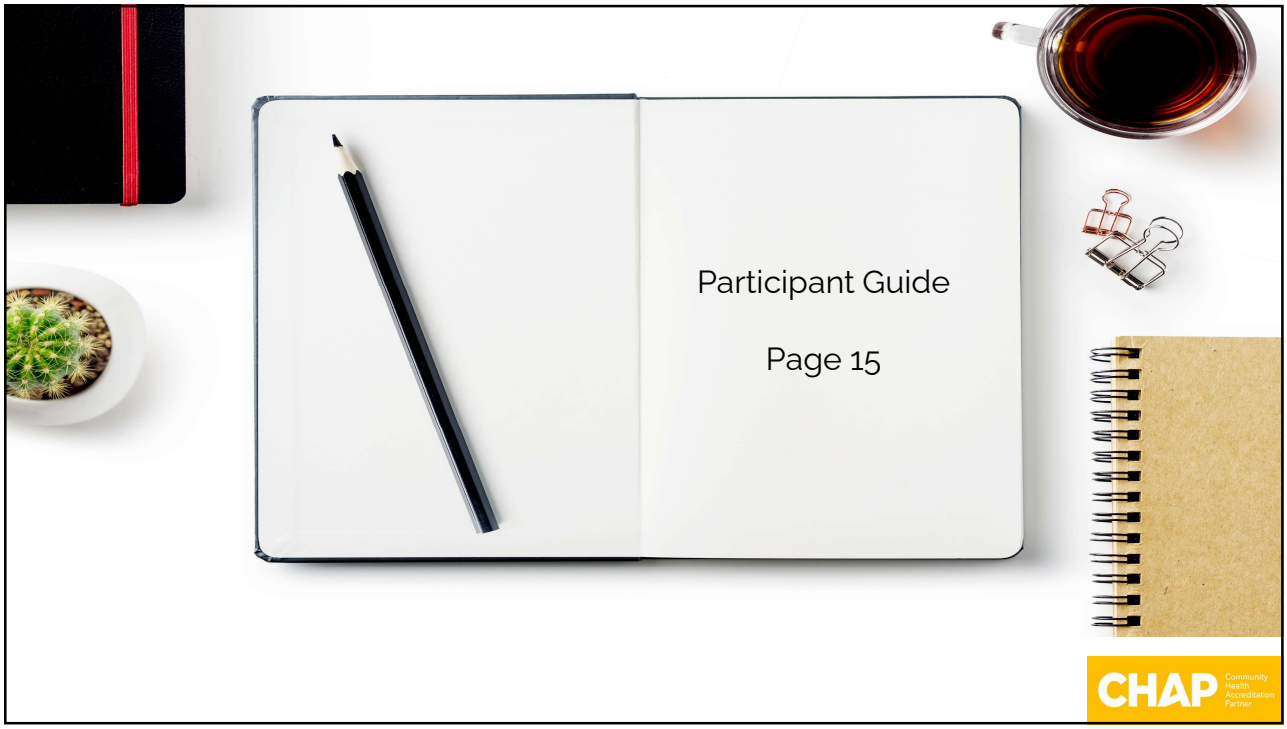

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Hospice Care, Delivery, and Treatment (HCDT)

KEY PERFORMANCE AREA

Care delivery and treatment are provided according to the patient's and family's needs and preferences, the hospice plan of care, and accepted standards of practice. The delivery of hospice care parallels the trajectory of the patient's illness and the changing needs of the patient and family.

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Provision of Care
HCDT 1.I – 3.I

Core Disciplines & Services
HCDT 4.I – 12.I

Aide Services
HCDT 15.I – 20.I

Volunteers
HCDT 21.I

Bereavement
HCDT 22.I

DME & Supplies
HCDT 26.I – 28.I

Drugs & Biologicals
HCDT 29.I – 35.I

Discharge & Transfer
HCDT 36.D – 40.I

Patient Death
HCDT 41.I

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HCDT Standard Summary

Hospice provides care and services in a manner consistent with accepted standards of practice.

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HCDT 1.I

The hospice is primarily engaged in providing the following care and services in a manner consistent with accepted standards of practice...

- Nursing, Medical social, and Physician services
- Hospice aide, volunteer, and homemaker services
- Physical therapy, Occupational therapy, and speech-language pathology services
- Short-term inpatient care
- Counseling services, including spiritual, bereavement, and dietary counseling
- Medical supplies (including drugs and biologicals) and medical appliances related to the palliation and management of the terminal illness and related conditions as identified in the care plan.

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Individual Activity

- Observe the home visit with Ms. Iris.
- Write down any concerns you might have about the visit as you watch.
- We will discuss it as a group once completed.

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Discussion…

55

Pause to Consider…

If you had observed this visit and overheard Ms. Iris state the aide had provided a bed bath instead of a shower, what are some follow-up actions you would take?

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Activity…

Take a few moments to read through the nurses' comprehensive assessment documentation again on pages 9-12.

What tasks would be appropriate for the RN to assign the aide to complete when providing care for Ms. Iris?

What instructions or precautions should the aide be aware of when providing care for Ms. Iris that should be included on the aide plan of care?

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HCDT 15.I
Aide Plan of Care

Hospice aides are assigned to a specific patient by a registered nurse who is a member of the Interdisciplinary Group.

Written patient care instructions for a hospice aide are prepared by a RN who is responsible for the supervision of the hospice aide.

HSRM 25.I
Aide Supervision

Hospice aides are supervised no less frequently than every **14 days.**

HCDT 16.I
Aide Following the Plan of Care

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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Discharge & Transfer Summaries

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HCDT 38.I
If the care of a hospice patient is transferred to a Medicare/Medicaid-certified facility, the hospice forwards to the receiving facility a copy of the hospice discharge summary

HCDT 39.I
If a patient revokes the election of hospice care or is discharged from hospice, the hospice forwards to the patient's attending physician a copy of the hospice discharge summary

HCDT 40.I
The hospice discharge summary provided to a facility receiving a hospice patient for care includes all the required components

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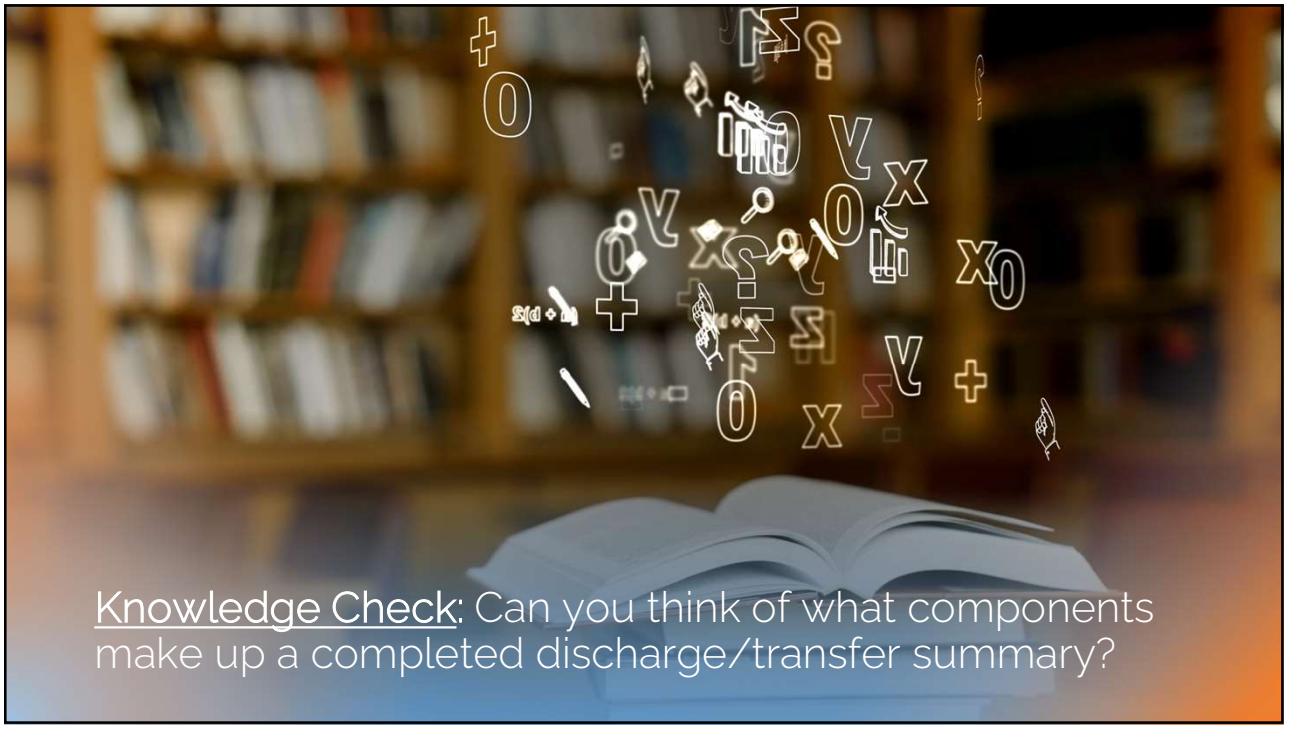

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Discharge/Transfer Summary Components

A summary of the patient's hospice stay, including treatments, symptoms, and pain management

The patient's current plan of care

The patient's latest physician orders

Any other documentation that will assist in the post-discharge continuity of care or that is requested by the receiving facility or the attending physician

HCDT 40.I

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2022 Top HCDT Findings

Standard	Content	CMS Tag
HCDT 16.I	Hospice Aide fulfills responsibilities within the plan of care (27%)	L 626
HCDT 15.I	Written aide instructions are prepared by RN (15%)	L 625
HCDT 39.I	Revocation of hospice benefit/discharge requires D/C summary (10%)	L 683
HCDT 40.I	Required elements of discharge summary (7%)	L 684
HCDT 38.I	Summary needed for transferred patient (7%)	L 682

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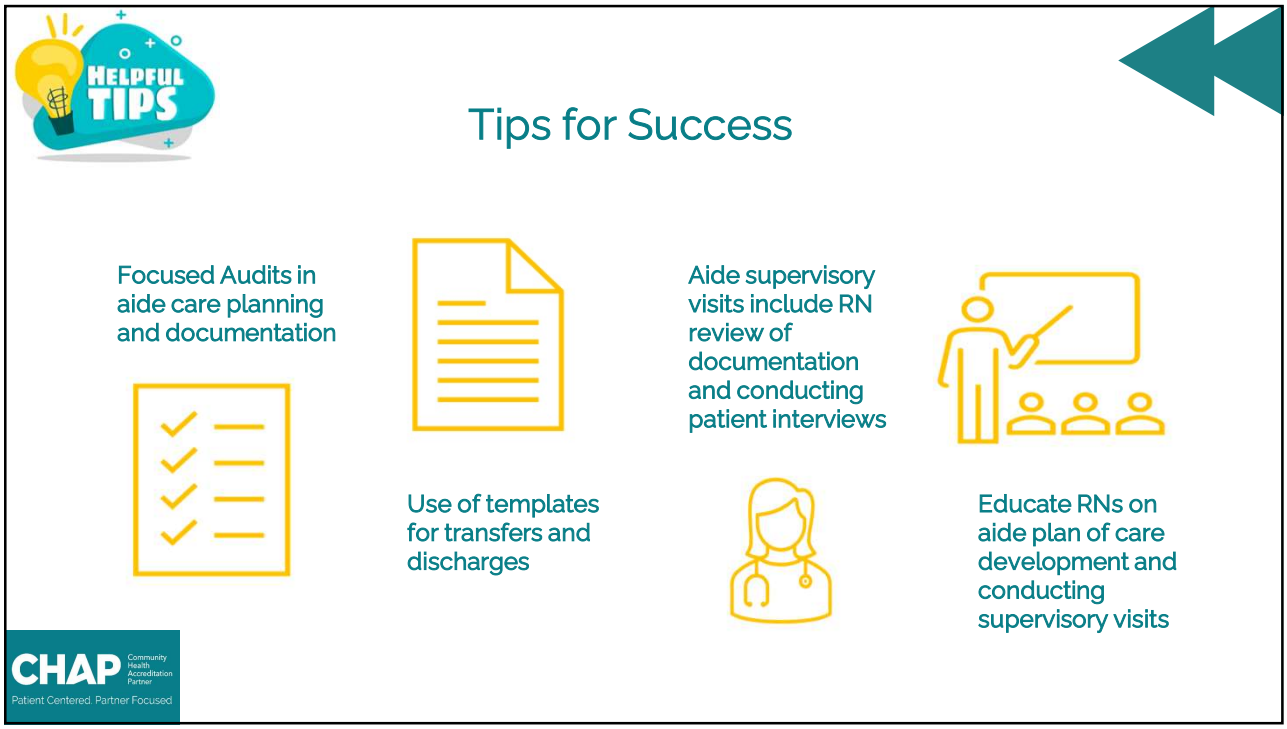
HELPFUL TIPS
Tips for Success
Focused Audits in aide care planning and documentation
Use of templates for transfers and discharges
Aide supervisory visits include RN review of documentation and conducting patient interviews
Educate RNs on aide plan of care development and conducting supervisory visits
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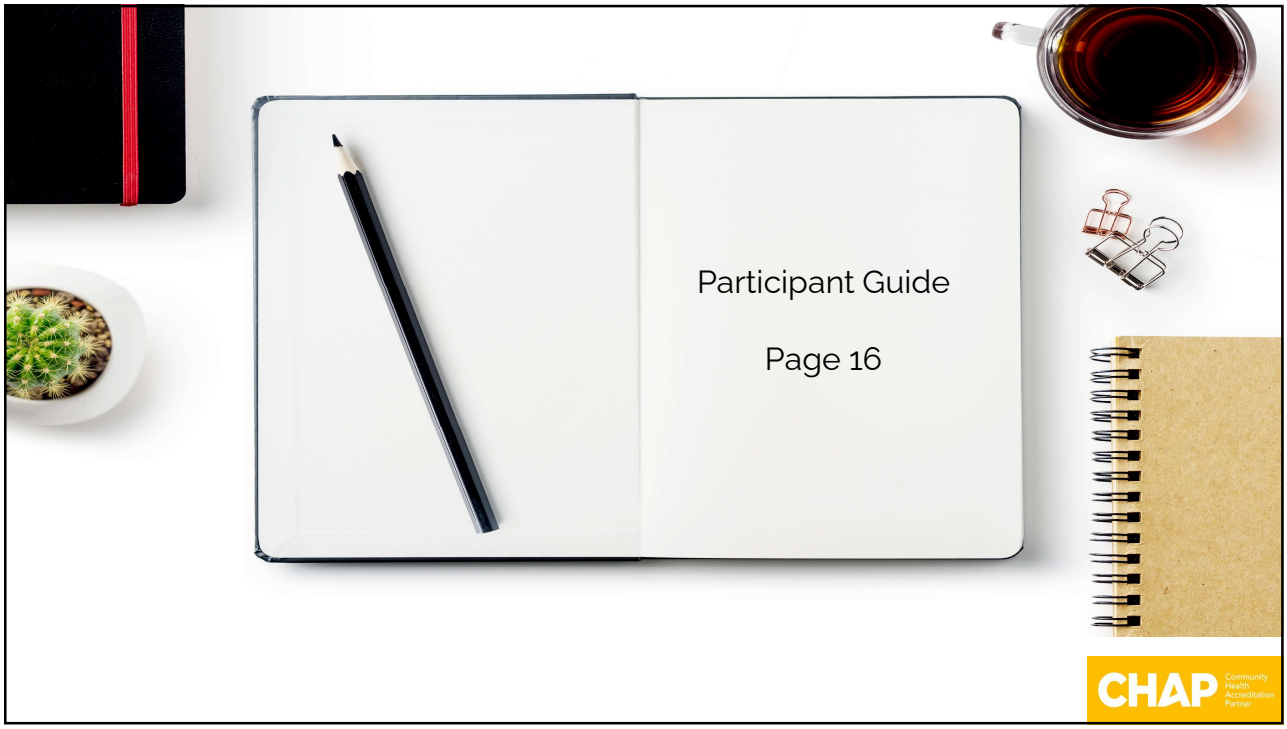

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Hospice Inpatient Care (HSIC)

KEY PERFORMANCE AREA

A hospice ensures that patients have access to inpatient care for the purposes of pain management, symptom management, and caregiver respite. The services may be provided by Medicare-certified facilities or a hospice-operated inpatient facility that meets the provisions of the following standards.

All facilities must ensure adequate nursing staff to meet the needs of the patient population, considering volume, acuity, and complexity of care being provided.

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- Have you ever worked with/in a hospice inpatient unit?
- Does the organization you are working with or consulting for have an inpatient unit?

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HSIC 1.I

Short-term Inpatient Care

Pain Control & Symptom Management

Caregiver Respite

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HSIC 5.D
Written Agreement

A hospice that provides short-term inpatient care under arrangement with a facility has a written agreement describing the arrangement and how the hospice coordinates the care; it includes at a minimum:

Hospice Responsibilities

- Plan of Care
- Inpatient clinical record
- Discharge summary
- Training documented
- Ensure requirements are met

Inpatient Provider Responsibilities

- Policies
- Discharge summary provided to hospice
- Inpatient record available
- Designated individual to ensure requirements are met

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Hospice:
Providing Inpatient Care Directly

HSIC 6.I – HSIC 34.I

Restraint & Seclusion

HSIC 35.I – HSIC 46.I

Staffing

Emergency Preparedness

Life Safety Code (LSC)

Facility Specifics: meals, pharmacy services

Medication Administration & Storage

Infection Control Program

Patient Rights

Use Follows Plan of Care

Physician Orders

Policies & Procedures

Staff Education & Competency

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Ms. Iris's hospice journey continues…

Over a 3-week period, Ms. Iris has had progressive difficulty with pain management. When admitted, the patient's pain was controlled with MS Contin 15mg BID and the use of MSIR for breakthrough pain.

In week two of her hospice certification period, her pain medication plan was changed to MS Contin 30mg BID with an increase in MSIR dosage and frequency.

In week three her medication regimen was changed to Fentanyl patches with Actiq lozenges; however, her pain continued and was not effectively managed. This has caused an increase in lack of sleep and anxiety, with additional medication changes needed.

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 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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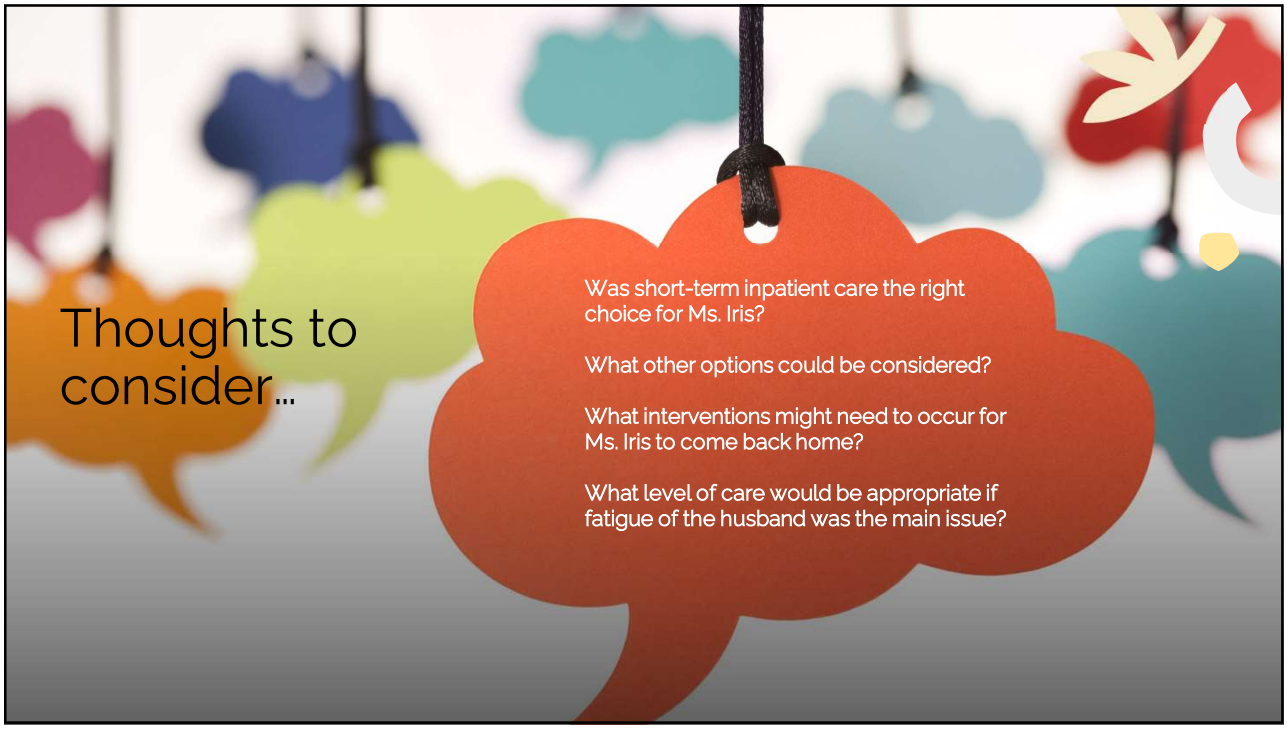

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2022 Top HSIC Findings

Standard	Content	CMS Tag
HSIC 28.I	Preparation/delivery/storage of meals (38%)	L836
HSIC 15.I	Documented and dated Life Safety Code fire drills (29%)	E0039
HSIC 24.I	Each patient room has control valves to regulate hot water (8%)	L832

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Tips for Success

All elements of written agreement are in place

Be aware of the responsibilities of both hospice and facility

For IPU, ensure meal prep follows patient's plan of care

For IPU, ensure process is in place for fire drills

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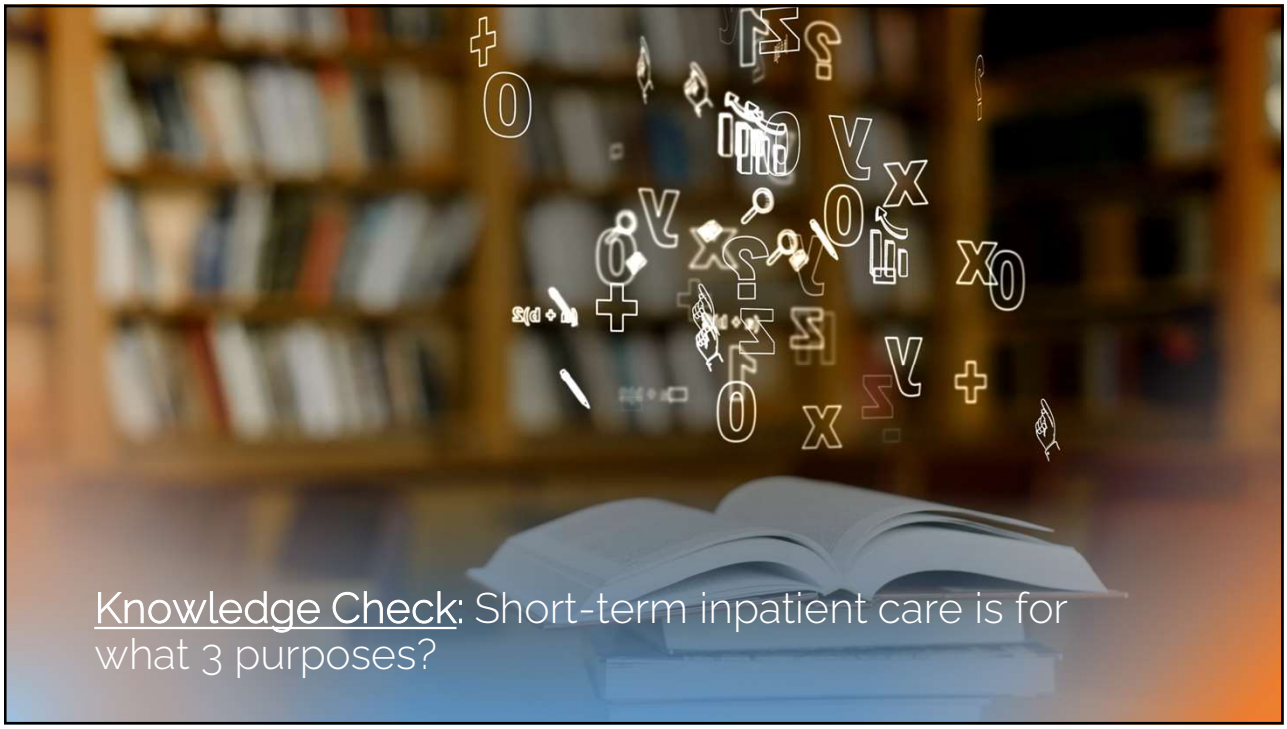
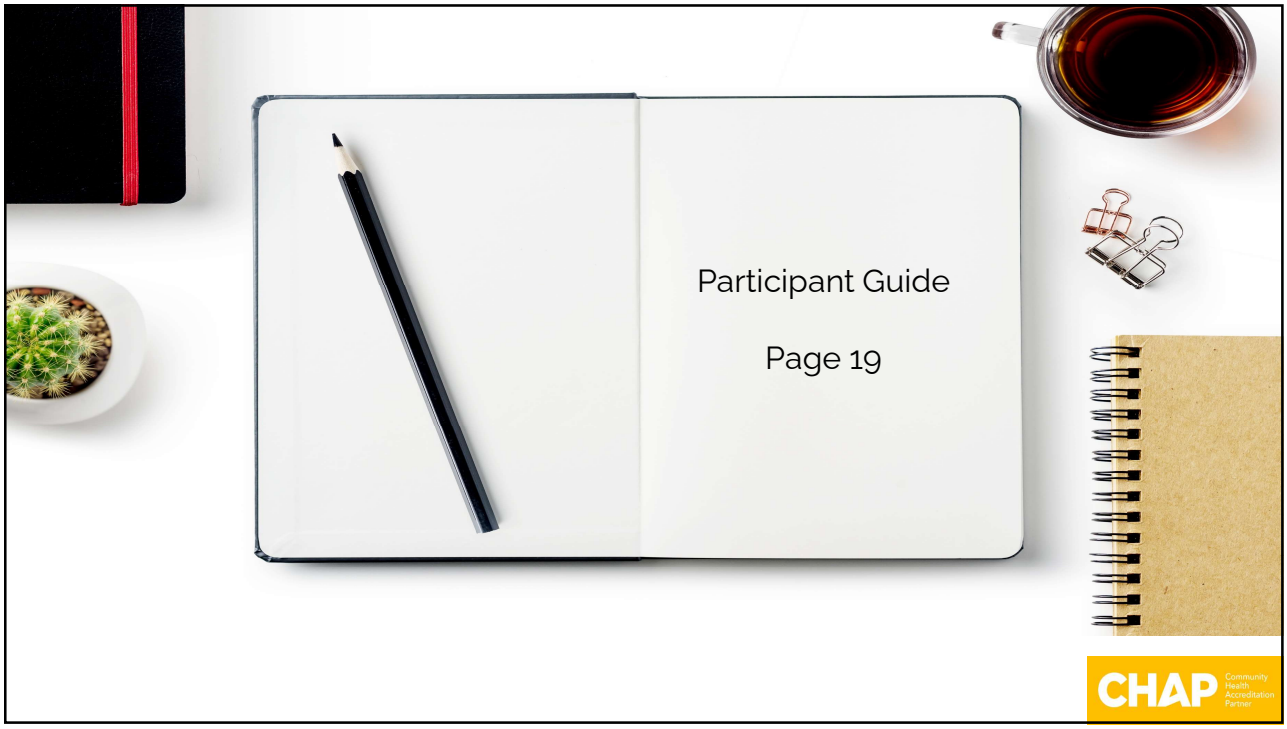

Knowledge Check: Short-term inpatient care is for what 3 purposes?

75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Hospice Care to Residents in a Facility (HSRF)

KEY PERFORMANCE AREA

Medicare beneficiaries who are also residents of SNFs (skilled nursing facilities)/NFs (nursing facilities) as well as ICFs (intermediate care facilities)/IDFs (intellectual disability facilities) have access to hospice care. All the same eligibility requirements and services are required. The main emphasis is an agreement and a process to coordinate the patient/resident's care with the facility staff, who assume a role similar to that of the family in the home. Home services are the same as if the resident lived in the community and services were provided by the hospice. The facility continues to provide room and board.

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- Within the organizations you work for/with, what would you say is the percentage of patients that reside in a facility?

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Hospice:
Professional Management & Responsibilities
HSRF 3.I & HSRF 4.I

Assessment
Initial, Comprehensive, & Ongoing

Financial Management
Medi-caid pass through, supplies, medications, etc.

Coordination
IDG, RN lead, Facility staff, Arranging for transfers as needed

Supplies/Medications/DME
Provided as needed and as related to the terminal illness

Care Provision
Core services, non-core services including aide services

Determining Level of Care
Routine, Continuous Care, GIP

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Responsibilities

Facility
Responsible for continuing to furnish 24-hour room and board 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.

Hospice
Responsible for providing services at the same level and to the same extent as those services would be provided if the SNF/NF or ICF/IDF resident were a patient in their own home (SNF/NF and ICF/IDF contract provisions).

Facility

Who's Responsible?

HSRF 5.I

Hospice

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HSRF 5.I
Written Agreements Components

Hospice
- 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

Facility
- 24-hour Room & Board
- Communication between Facility & Hospice staff
- Notify hospice of a change in condition, need to transfer, or patient dies

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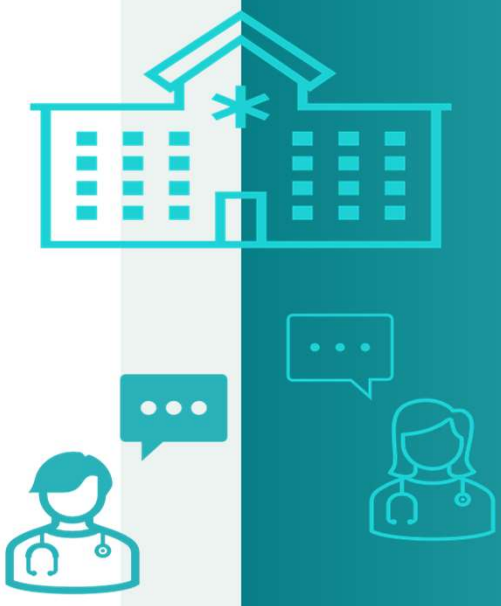

Ms. Iris' Story Continues…

Following her GIP stay, Iris is admitted as a custodial patient to the skilled nursing facility on routine level of care until her daughter can return and provide care for her mother.

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?

- Provision of meals
- Physician call upon worsening of symptoms
- Providing a chair bath 3 times per week
- Assisting with incontinence
- Determining the bowel regimen
- Implementing the bowel regimen
- Determines a need for changing the level of care
- Financial responsibility for long-term incontinence supplies
- Financial responsibility for medications addressing the terminal illness

- Provision of meals **(2)**
- Physician call upon worsening of symptoms **(1)**
- Providing a chair bath 3 times per week **(1 & 2)**
- Assisting with incontinence **(2)**
- Determining the bowel regimen **(1)**
- Implementing the bowel regimen **(2)**
- Determines a need for changing the level of care **(1)**
- Financial responsibility for long-term incontinence supplies **(2)**
- Financial responsibility for medications addressing the terminal illness **(1)**

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HSRF 6.I

Hospice care of the patient/resident is stated in a written plan of care established and maintained in consultation with SNF/NF or ICF/IDF representatives.

One

The hospice plan of care identifies the care and services that are needed and specifies which provider is responsible for performing the functions that are agreed upon and included in the plan of care.

Two

The plan of care reflects the participation of the hospice, the SNF/NF or ICF/IDF, and the patient and family to the extent possible.

Three

All hospice care is provided in the facility in accordance with the hospice plan of care.

Four

Any changes to the hospice plan of care are discussed with the patient or representative and SNF/NF or ICF/IDF representatives and are approved by the hospice before implementation.

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HSRF 9.I

The designated IDG member provides the SNF/NF or ICF/IDF with the following information for each patient/resident:

One
The most recent hospice plan of care

Two
Hospice election form and any advance directives

Three
Physician certification and recertification of the terminal illness

Four
Names and contact information for hospice staff involved in the patient's care

Five
Instructions on how to access the hospice's 24-hour on-call system

Six
Hospice medication information

Seven
Hospice physician and attending physician (if any) orders

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2022 Top HSRF Findings

Standard	Content	CMS Tag
HSRF 6.I	Hospice plan of care present/coordination occurs with facility (56%)	L 774
HSRF 9.I	Clinical record required components (38%)	L781

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Tips for Success

All elements of written agreement are in place

Be aware of the responsibilities of both hospice and facility

Documentation reflects coordination; hospice plan of care present and shows which provider is responsible for each intervention

Facility record contains all required components

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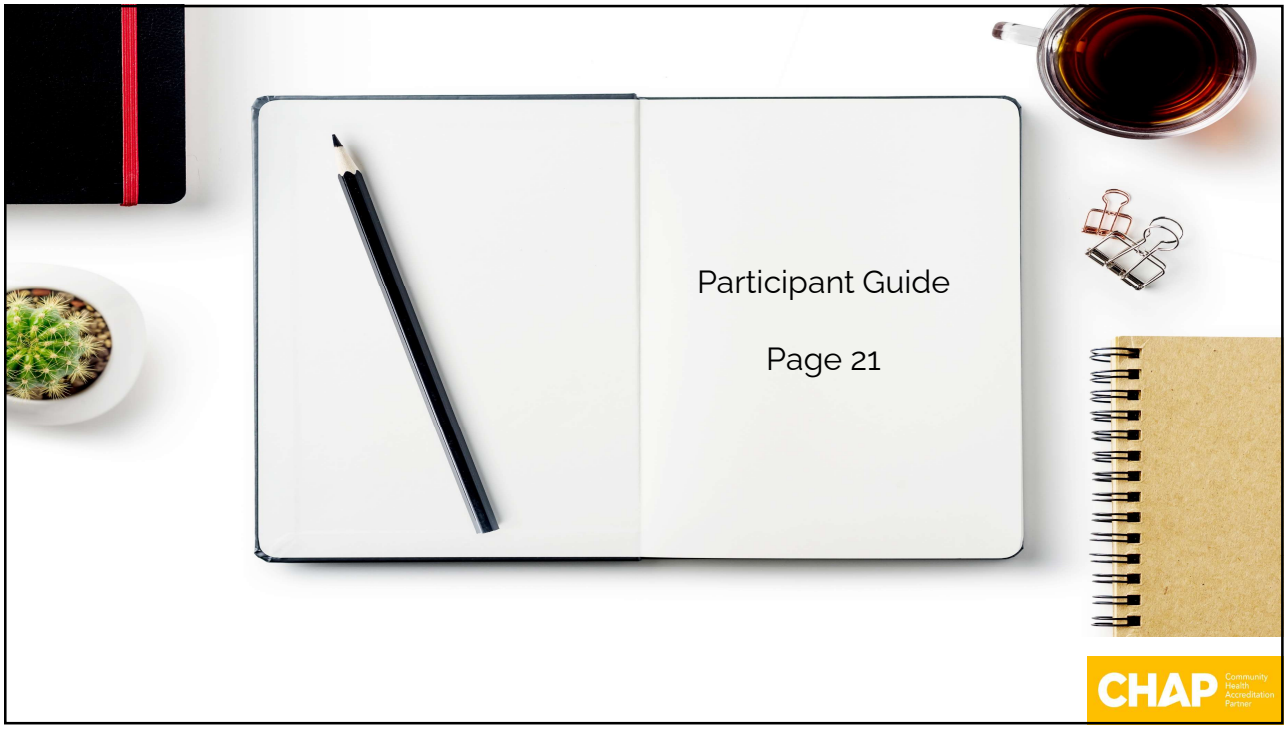
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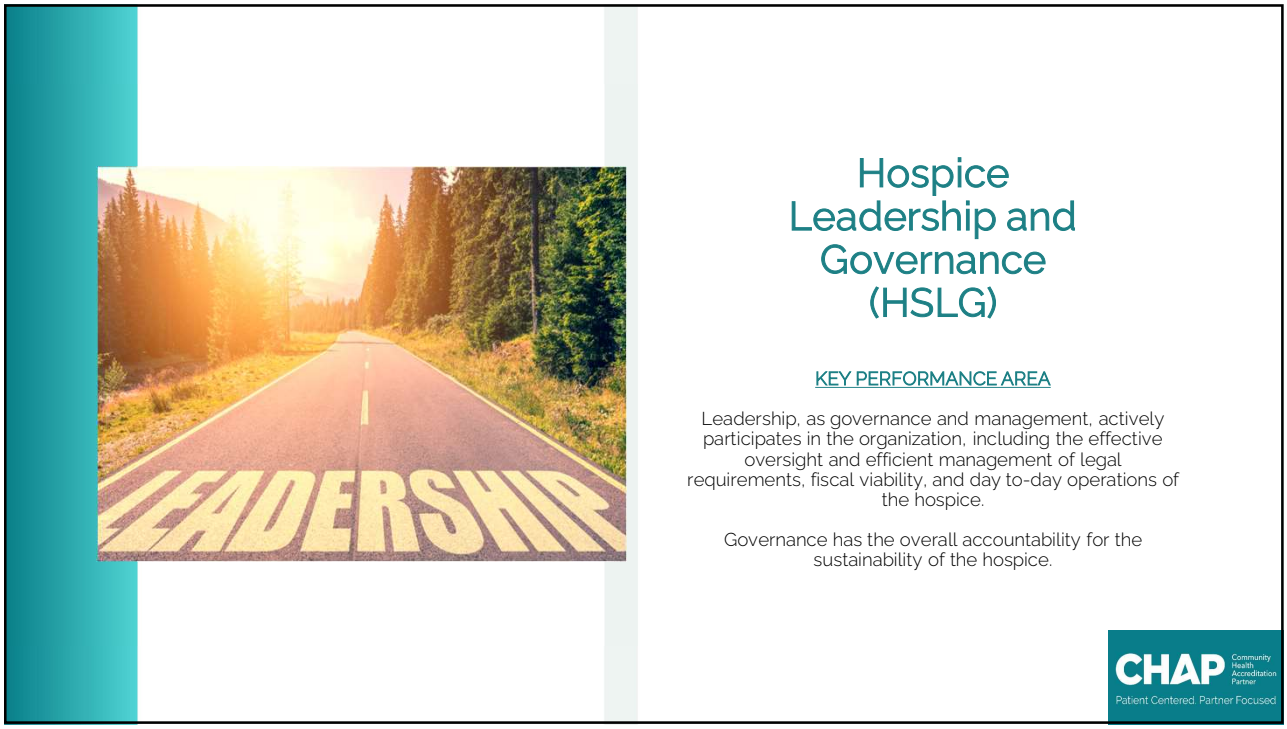
LEADERSHIP
Hospice Leadership and Governance (HSLG)
KEY PERFORMANCE AREA
Leadership, as governance and management, actively participates in the organization, including the effective oversight and efficient management of legal requirements, fiscal viability, and day to-day operations of the hospice.
Governance has the overall accountability for the sustainability of the hospice.
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HSLG 2.I

The hospice's governance (or designated person(s) so functioning) assumes full legal authority and responsibility for the organization's:

- Overall Management and Operation
- Provision of Care and Services
- Fiscal Operations
- Ongoing Performance Improvement and Patient Safety Program that is Defined, Implemented, Maintained, and Evaluated Annually

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If the administrator is not available, another individual is assigned the administrator's duties and responsibilities as defined in policy and procedure.

HSLG 3.I

A qualified administrator is appointed by and reports to the governing body and is responsible for day-today hospice operation.

The hospice administrator:

- Is an employee of the organization
- Informs the governing body about ongoing operations, including patient care delivery issues and QAPI activities
- Has the education and experience as required by the governing body

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HSLG 7.1 Volunteers

Hospice volunteers provide day-to-day administrative or direct patient care services in an amount that, at a minimum, **equals five percent (5%)** of the total patient care hours of all paid hospice employees and contract staff.

- The hospice documents the cost savings achieved through volunteers.

  Documentation includes…
- The identification of each position that is occupied by a volunteer
- The work time spent by volunteers occupying those positions
- Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions noted

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HSLG 9.1 – 10.1 DME

Hospice ensures DME is in safe working order

The hospice ensures that the manufacturer's guidelines for performing routine maintenance and preventive maintenance are followed.

The hospice ensures that repair and maintenance policies are developed when manufacturer's guidelines for a piece of equipment do not exist.

The hospice may use persons under contract to ensure maintenance and repair of durable medical equipment.

Hospice may contract with a Medicare-certified point-of-service (POS) supplier that:

- Meets the CMS DMEPOS Supplier Quality and Accreditation standards
- Has a letter verifying that the DMEPOS supplier is accredited by a recognized accreditation organization.

20 %

HSLG 8.1 Inpatient Days

The total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period may not exceed **20 percent** of the total number of hospice days consumed in total by Medicare beneficiaries.

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HSLG 14.D
Written Agreements

A written agreement with another organization or individual to furnish hospice care or services includes:

- The scope of services to be provided
- How Interdisciplinary Group (IDG) management oversight and coordination is provided
- How communication with the IDG and hospice administration occurs
- Care provided only upon authorization of the hospice
- Care provided in a safe and effective manner and by qualified personnel that meet the human resources requirements of the hospice
- Care delivered in accordance with patient's plan of care

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2022 Top HSLG Findings

Standard	Content	CMS Tag
HSLG 2.I	Governance assumes full authority (36%)	L574,L651
HSLG 14.D	Required elements of written agreement to furnish services (21%)	L 655
HSLG 3.I	Qualified administrator and alternate is appointed (14%)	L651

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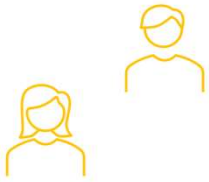
Tips for Success

All elements of written agreement are in place

Ensure oversight of the Volunteer Program

Ensure governing body is involved and assumes oversight of hospice program with special focus on the QAPI program



Qualified Administrator is appointed with alternate in place

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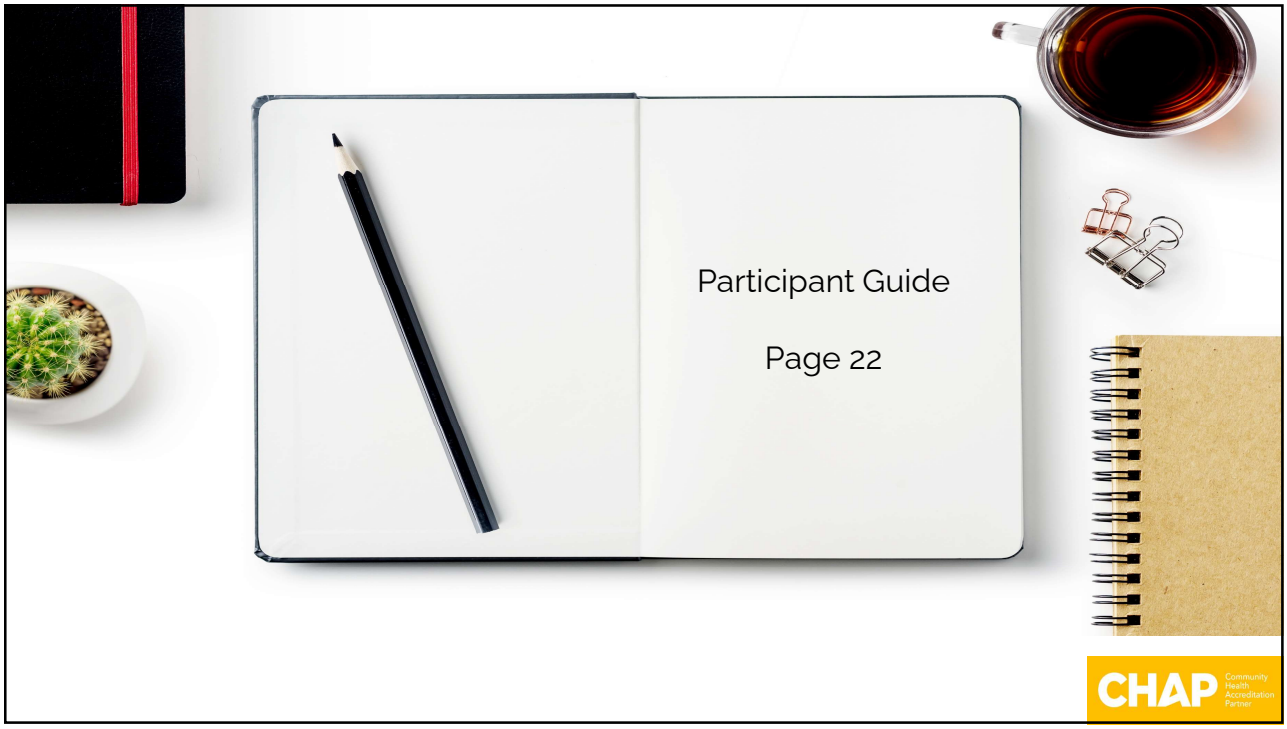
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Hospice Information Management (HSIM)

KEY PERFORMANCE AREA

The hospice's effective use of information supports clinical improvement and business intelligence. Whether paper or electronic, the system for using the data requires defined processes to collect, store, retrieve, transmit, and protect data.

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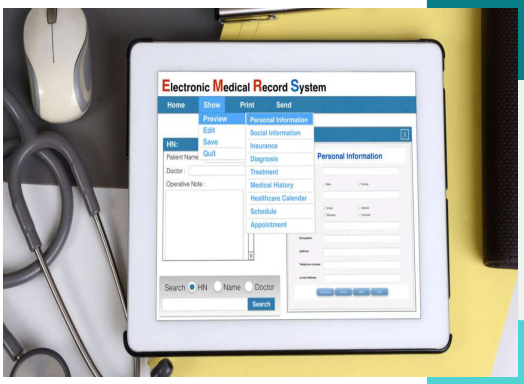
HSIM 2.I Standardized Formats

The hospice uses standardized formats, data elements, and a system for documenting information and storing it for easy access. The system is used for:

The hospice has a list of abbreviations, acronyms, or symbols that cannot be used by staff.



Operational information (e.g., financial, staffing, etc.)

Personnel Information

A record of the delivery of care and services.

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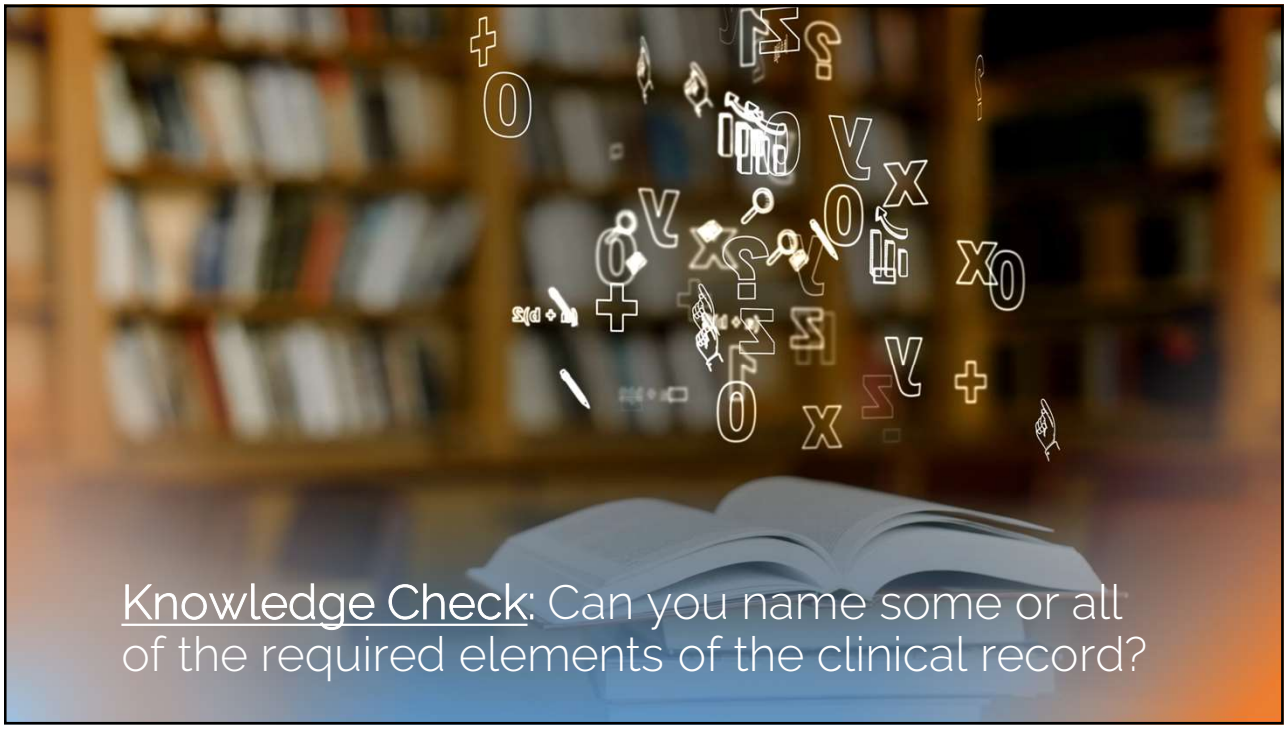

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HSIM 3.I
Contents of the Clinical Record

- ✓ Initial plan of care and updates
- ✓ Initial and comprehensive assessments with updates

- ✓ Clinical notes
- ✓ Signed copies of patient rights
- ✓ Election statement
- ✓ Responses to medications, symptom management, treatments, and services
- ✓ Outcome measure data elements per regulation

- ✓ Physician certification and recertification of terminal illness
- ✓ Advanced directives
- ✓ Copies of inpatient discharge summary, if applicable
- ✓ Physician orders

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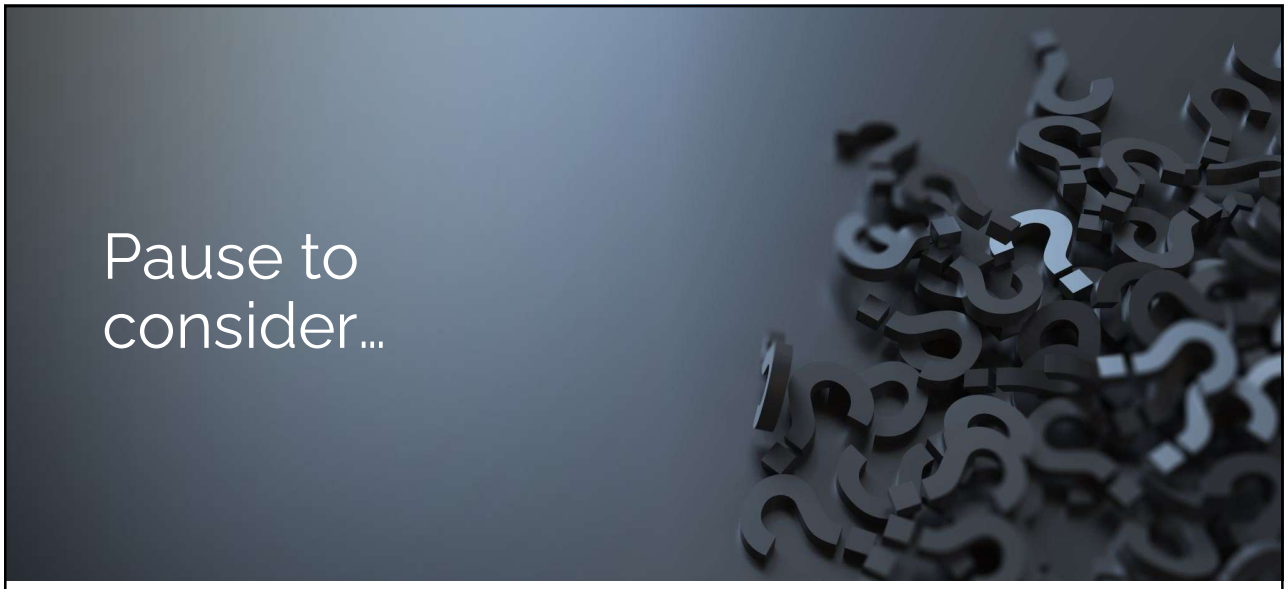
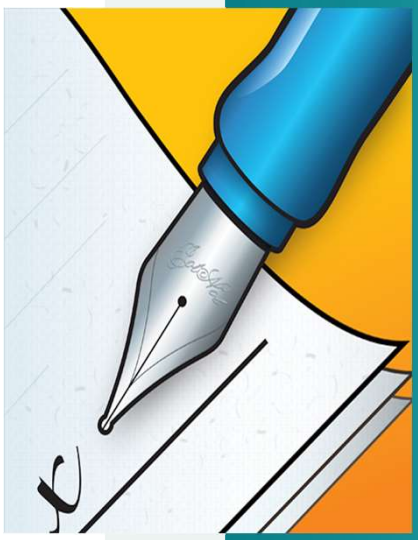


Which of the required clinical record elements do your organizations have the most challenges with?

105



HSIM 4.I

Entries in the Patient Record

All entries in the patient record are legible, complete, and appropriately authenticated and dated by the person performing the care/service in accordance with hospice policy and with currently acceptable standards of practice.

The hospice has a means to authenticate entries or to identify the author of each entry.

- If the hospice uses electronic records, electronic authentication utilizes a user ID and password protection.

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2022 Top HSIM Findings

Standard	Content	CMS Tag
HSIM 4.I	Record entries are legible, authenticated, and dated (92%)	L 679
HSIM 2.I	Standardized formats, data elements. "Do Not Use" list (6%)	NA
HSIM 3.I	Elements of the clinical record (2%)	L 678 L 673

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Tips for Success

Incorporate process of validating authentication of documentation in clinical record audit process

Ensure staff have access to "Do Not Use" abbreviation policy

Ensure clinical record audit process includes validating completeness of all documentation entries

Incorporate use of templates as appropriate to ensure all required elements of documentation are completed

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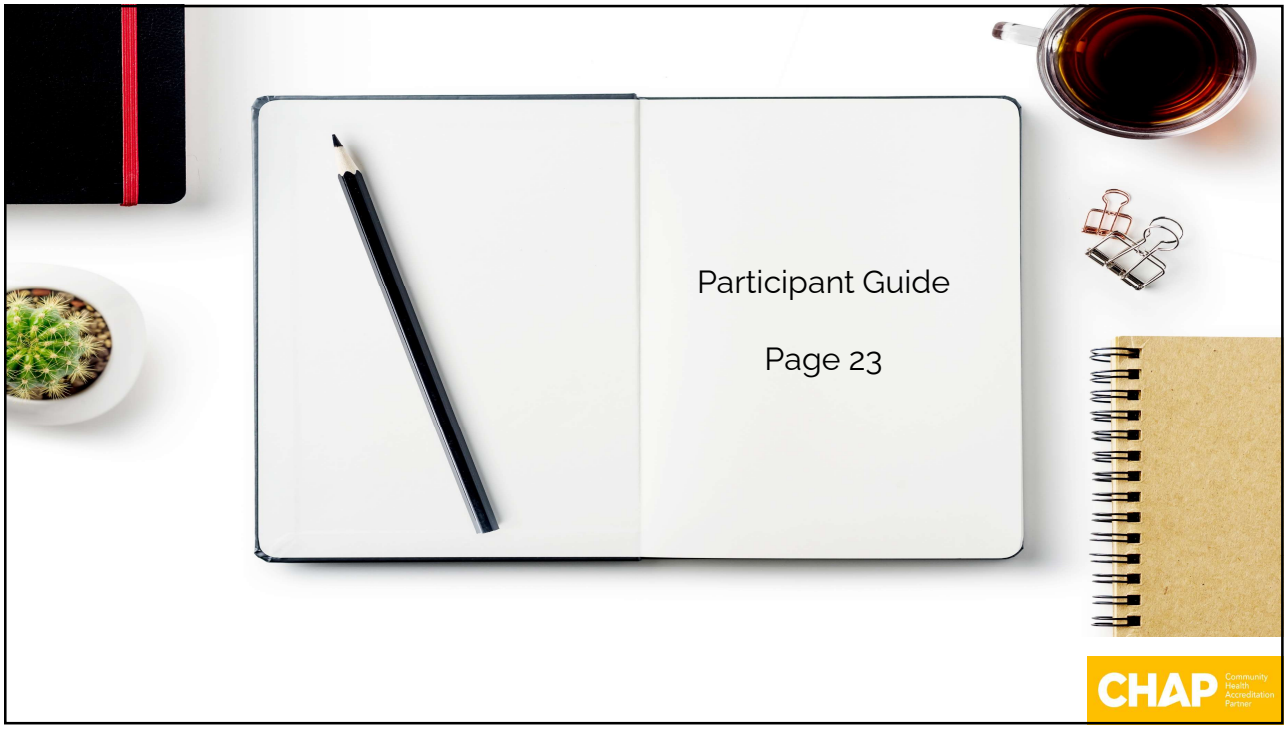

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CMS Revised Hospice Survey Process

"A significant change in the hospice survey protocol is an enhanced approach to investigating the quality of care provided to hospice patients."

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- Are you aware CMS revised the hospice survey process?
  - Yes
  - No

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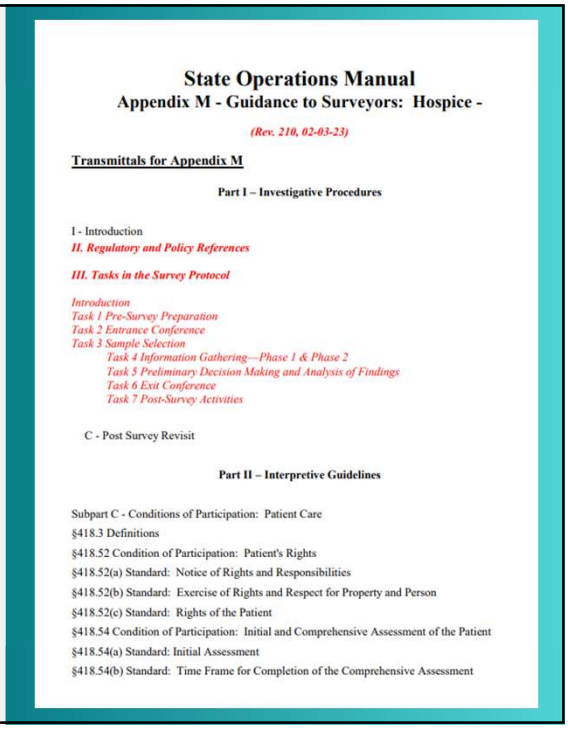
Revision to the State Operations Manual – Appendix M Hospice – Guidance for Surveyors

- Incorporates changes made in surveyor training and survey process in HOSPICE Act
- Incorporates 1135 waivers that were made permanent
- Increased pre-survey preparation
- Focus on quality of care with **4 core hospice Conditions of Participation**
- Increased focus on reporting mistreatment and all types of abuse
- **NO change to conditions of participation**
- All CoPs surveyed equally



State Operations Manual
Appendix M - Guidance to Surveyors: Hospice -
(Rev. 210, 02-03-23)

Transmittals for Appendix M

Part I – Investigative Procedures

I - Introduction
II. Regulatory and Policy References
III. Tasks in the Survey Protocol
Introduction
Task 1 Pre-Survey Preparation
Task 2 Entrance Conference
Task 3 Sample Selection
Task 4 Information Gathering—Phase 1 & Phase 2
Task 5 Preliminary Decision Making and Analysis of Findings
Task 6 Exit Conference
Task 7 Post-Survey Activities

C - Post Survey Revisit

Part II – Interpretive Guidelines

Subpart C - Conditions of Participation: Patient Care
§418.3 Definitions
§418.52 Condition of Participation: Patient's Rights
§418.52(a) Standard: Notice of Rights and Responsibilities
§418.52(b) Standard: Exercise of Rights and Respect for Property and Person
§418.52(c) Standard: Rights of the Patient
§418.54 Condition of Participation: Initial and Comprehensive Assessment of the Patient
§418.54(a) Standard: Initial Assessment
§418.54(b) Standard: Time Frame for Completion of the Comprehensive Assessment

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4 Core: Conditions of Participation

CoPs that contribute to understanding the **quality of care** delivered directly to patients, their caregivers, and families.

1	2	3	4
Patient's Rights	Initial and Comprehensive Assessment	Interdisciplinary Group, Care Planning and Coordination of Care	Quality assessment and performance improvement.
§418.52	§418.54	§418.56	§418.58

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Focused Hospice Survey Process with 2 sequential "Phases"

Phase 1

3 Core Requirements
6 Associated CoPs
Direct care of the patient and family
Uses home visits, observations and interviews

Phase 2

1 Core Requirement
13 Associated CoPs
Uses review of development and execution of administrative and structural factors, e.g. QAPI plan, review of waivers, furnishing core and special services, etc.

Information Gathering

Appendix M

Investigative Phases

- Phase 1: directly impacts quality of care.
- Phase 2: indirectly impacts quality of care.

Focused Hospice Survey Process with 2 Phases	
	Phase 1 3 Core Requirement CoPs. 6 Associated CoPs. Measures quality of care provided to patient and family. Surveyors use home visits and observations, interviews, and record review.
	Phase 2 1 Core Requirement CoP. 13 Associated CoPs. Measures quality assessment and performance improvement (QAPI). Surveyors review hospice agency documentation and supplement with observations and interviews.

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Phase 1
Information Gathering

3 core CoPs:

§418.52 Condition of Participation: Patient's Rights

§418.54 Condition of Participation: Initial and Comprehensive Assessment of the Patient

§418.56 Condition of Participation: Interdisciplinary Group, Care Planning, and Coordination of Services

6 associated CoPs:

- §418.60 Condition of participation: Infection Control
- §418.76 Condition of Participation: Hospice Aide and Homemaker Services
- §418.102 Condition of Participation: Medical Director
- §418.108 Condition of Participation: Short-term Inpatient Care
- §418.110 Condition of Participation: Hospices that Provide Inpatient Care Directly
- §418.112 Condition of Participation: Hospices that Provide Hospice Care to Residents of a SNF/NF or ICF/IID

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Phase 2
Information Gathering

1 core CoP:

§418.58 Condition of Participation: Quality Assessment and Performance Improvement

13 associated CoPs:

- §418.62 Condition of Participation: Licensed Professional Services
- §418.64 Condition of Participation: Core Services
- §418.66 Condition of Participation: Nursing Services Waiver Of Requirement That Substantially All Nursing Services Be Routinely Provided Directly by a Hospice
- §418.70 Condition of Participation: Furnishing of Non-core Services
- §418.72 Condition of Participation: Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP)
- §418.74 Waiver of Requirement-Physical Therapy, Occupational Therapy, Speech Language Pathology and Dietary Counseling
- §418.78 Condition of participation: Volunteers
- §418.100 Condition of Participation: Organization and Administration of Services
- §418.104 Condition of participation: Clinical Records
- §418.106 Condition of Participation: Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment
- § 418.113 Condition of participation: Emergency preparedness
- §418.114 Condition of Participation: Personnel Qualifications
- §418.116 Condition of Participation: Compliance with Federal, State, and Local Laws and Regulations Related to the Health and Safety of Patients

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Survey Activity
Home Visits

1

Purpose of the Home Visit is to Evaluate:

- Care provided by the Hospice meets the health and safety standards of the Medicare program
- Agency protects and promotes patient rights
- Comprehensive assessment is current
- Care provided is consistent with the patient's plan of care

2

The Home Visit is:

- The only opportunity for the surveyor to observe the direct care provided by Hospice personnel.
- The most important means of information gathering during the hospice survey.

3

The surveyor uses observation and interview skills to assess the hospice's adherence to the requirements.

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Survey Activity
Interviews with Patients, Families, and Staff

1

The objective of hospice interviews with patients, family/caregivers and staff is to further investigate and confirm findings identified during record reviews, observations, and to clarify other interviews.

2

Interview questions are utilized based on the patient/family situation and responses.

3

Must include IDG staff members who provide clinical care directly.

- RN whose primary function is the care of the patient and coordination of care between the patient and the IDG, is the most critical.

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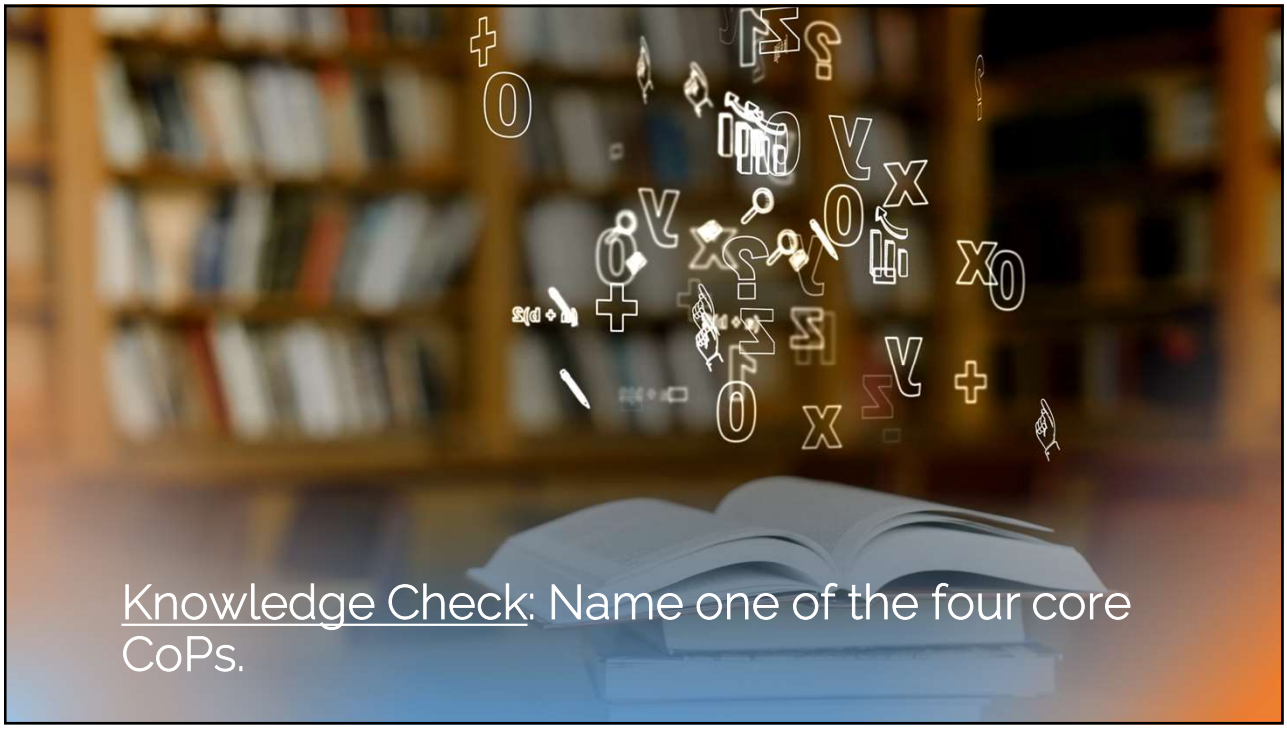
Knowledge Check: Name one of the four core CoPs.

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What is your
"Golden Nugget"
from today's
sessions?

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Questions

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Day 1

Community Health Accreditation Partner (CHAP) / v.2.1.0 Hospice Standards of Excellence - Updated August 5, 2023

https://www.cms.gov/files/document/qso-23-08-hospice.pdf

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_m_hospice.pdf

https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SOM%20Appendix%20Z%202019.pdf

https://www.nhpco.org/wp-content/uploads/Volunteer_FAQs.pdf

https://www.nhpco.org/wp-content/uploads/Respite_Tip_sheet.pdf

https://www.nhpco.org/wp-content/uploads/GIP_FAQs.pdf

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Thank You

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