Hospice Consultant Certification

An Interactive Virtual Training

Bobbie Warner RN, BSN
Senior Program Manager

Housekeeping

- Introductions
- Agenda and Handouts
- Muting
- Use of Chat
- Raise of hand
Name – State – Why Hospice

Get to Know You Using Microsoft Polls

- How long have you worked as a consultant?
- Are you familiar with CHAP Hospice Standards of Excellence?
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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**CHAP Standards of Excellence**

- Revisions
- Version
- Evidence Guidelines
Additional Resources

- Appendix M – State Operations Manual (SOM) Conditions of Participation
- Appendix Z – State Operations Manual (SOM) for Emergency Preparedness
- MLN newsletters and CHAP eNews


Participant Guide
Page 6
Hospice Patient/Family Centered Care (HPFC)

- 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
- Confidential record per law and regulation
- Received effective pain management and symptom control
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

2022 Top Findings in HPFC

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

Initial organization, passed survey through deemed CHAP Accreditation visit two months ago. Current census – 30.

Has contract in place for short term inpatient care, and respite services.

Administrator is non-clinical, Clinical Director is new to hospice but has managerial experience in home health.

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.
Hospice Assessment, Care Planning and Coordination

HCPC
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

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
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

Comprehensive Assessment Elements

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

Scenario

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, you are evaluating the admission documentation and process.

Group Activity – 20 minutes

- Attendees will be divided into four breakout rooms
  - Each participant should conduct a high-level overview of the entire assessment
    - Pages 10-12
    - Each group addresses their assigned task
      - Evaluate what was documented
      - Make suggestions for improvement
  - Each group will be assigned key elements of the assessment for in-depth review
    - **Group one** – focus on vital signs and pain assessment
    - **Group Two** – focus on psychosocial aspects
    - **Group Three** – focus on functional aspects
    - **Group Four** – focus on Medication aspect
    - **Group Five** – focus on coordination aspects
  - Each group assigns one spokesperson to share their thoughts.
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

**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.
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

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

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.
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

HCDT 9.1 – 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
**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 O2

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

**Endocrine**
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**Coping**
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### Activities of Daily Living
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**Patient Name:** Iris Wood  
**Diagnosis:** Pancreatic Cancer with liver Metastasis

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| **DOB:** 3/23/1952  
**SOC:** 7/22/2021 |   |
| **Crestor 10 mg PO daily**   |   |
| **MS Contin 15 mg every 12 hours** |   |
| **Ativan 0.5 mg PO PRN**    |   |
| **Tylenil 3.25 mg PO PRN**  |   |
| **Atenolol 25 mg PO daily; hold heart rate <50** |   |
| **Digoxin .25 mg daily**   |   |
| **Albuterol 2.5 mg via nebulizer q 6-hour PRN for shortness of breath wheezing** |   |
| **Comfort Kit**             |   |
| **DME**                     |   |
| **Walker**                  |   |
| **10 L concentrator**       |   |
| **Hospital bed**            |   |
| **Overbed table**           |   |
| **Nebulizer**               |   |

**CHAP**

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**Patient Name:** Iris Wood  
**Diagnosis:** Pancreatic Cancer with liver Metastasis

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**CHAP**

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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

Interdisciplinary Group

**HCPC 18.1**
Interdisciplinary Group prepares a written plan of care in consultation with the attending physician.

**HCPC 19.1**
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 20.1**
Patient and family receive education and training appropriate to their responsibilities.
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.

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
Individual Activity

- Participants will review the Plan of Care in their participant guide on pages 14-15 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
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:

**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 softer, 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.
**PATIENT/FAMILY**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Alteration in ability to care for personal care needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td>Patient's personal care needs will be met safely and effectively.</td>
</tr>
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**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
2022 Top Findings in HCPC

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<tr>
<td>HCPC 21.1</td>
<td>Elements of the Plan of Care (25%)</td>
<td>L545, L548</td>
</tr>
<tr>
<td>HCPC 15.1</td>
<td>Medication Profile and Drug Review (18%)</td>
<td>L530</td>
</tr>
<tr>
<td>HCPC 9.1</td>
<td>Assessment within 5 days in accordance with elements of the hospice election statement (13%)</td>
<td>L523</td>
</tr>
<tr>
<td>HCPC 19.1</td>
<td>Designated RN coordinates care/individualized plan of care in collaboration with physician, patient, primary caregiver (13%)</td>
<td>L540, L543</td>
</tr>
<tr>
<td>HCPC 18.1</td>
<td>Interdisciplinary Group in consultation with the physician develop the written plan of care (7%)</td>
<td>L538</td>
</tr>
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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 15.1; 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
**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**

*L 543* - All hospice care and services furnished to patients and their families must follow an individualized written plan of care.

**Top Findings in HCPC**

**HCPC18.I; 418.56 – Plan of Care**

*L 538* - The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.
Tips for Success

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

**HCDT**

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 |
Provision of all Services

HCDT.5-12.I

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

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

HCDT.13-21

Non-Core Services
- Physical therapy, Occupational therapy, Speech Language Pathology
- Hospice aide and homemaker services
- Volunteer services
Discussion

Interdisciplinary Team Meeting

Review the IDT note from the first meeting held after the visit observed with Ms. Iris (pages 18-19)

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

Prepare for a robust discussion
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
**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

**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
**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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**2022 Top Findings in HCDT**

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

1. Policies for remote monitoring
2. Templates for transfer/discharge
3. Aide documentation coordinates with the written aide plan of care
4. Supervisory visits include review of documentation and patient interview
5. Interdisciplinary team processes
   - Addressing absent members
   - Ensuring appropriate discussion
   - Agenda for meeting
   - Documentation template
Hospice Inpatient Care (HSIC)

Standard Review (1)

HSIC1.l – 4.l General inpatient standards

- Eligibility
- Pain and symptom management control
- Medicare certified facility
Standard Review (2)

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

- Hospice responsibilities
- Facility responsibilities

Agreement Requirements

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

**Inpatient Provider:**
- Policies
- Clinical Record
- Inpatient record available
- Designated individual
Standard Review (3)

HSIC 6.1 – 34.1 Direct owned IPU

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

Standard Review (4)

HSIC 35.1 - 46.1 – Restraint and seclusion

- Use of
- Plan of Care
- Policies and procedures
- Responsible staff
- Training
# Direct or Under Arrangement

<table>
<thead>
<tr>
<th>Under Arrangement</th>
<th>Direct</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Written Agreement</td>
<td>• Appropriate staffing/24 Hour Nursing</td>
</tr>
<tr>
<td>• Ensuring facility complies with Life Safety Code</td>
<td>• Responsible for Emergency Preparedness</td>
</tr>
<tr>
<td>• Infection control as per hospice policy</td>
<td>compliance: policies/testing/communication</td>
</tr>
<tr>
<td>• Complies with restraint/seclusion requirements</td>
<td>• Life Safety Code Compliance</td>
</tr>
<tr>
<td></td>
<td>• Facility specific infection control</td>
</tr>
<tr>
<td></td>
<td>• Policies related to restraint/seclusion</td>
</tr>
</tbody>
</table>

## Ms. Iris

![Image of Ms. Iris](image)
Iris’s pain management

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 increase Dilaudid 8mg for breakthrough pain. In week three Fentanyl patches with Actiq lozenges were unable to provide her acceptable relief.

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.
Thoughts to Consider

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

What other options could be considered?

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

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

---

2022 Top Findings in HSIC

<table>
<thead>
<tr>
<th>Standard</th>
<th>Content</th>
<th>CMS Tag</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSIC 28.I</td>
<td>Preparation/delivery/storage of meals (38%)</td>
<td>L736</td>
</tr>
<tr>
<td>HSIC 15.I</td>
<td>Documented and dated Life Safety Code fire drills (29%)</td>
<td>E0039</td>
</tr>
<tr>
<td>HSIC 24.I</td>
<td>Each patient room has control valves to regulate hot water (8%)</td>
<td>L732</td>
</tr>
</tbody>
</table>
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 addressed through quality program
Hospice Care to Residents in a Facility

HSIC and HSRF

**Similarities**
- Written Agreement
- Financial Responsibility
- Hospice Standards and Plan of Care

**Differences**
- Bereavement responsibilities
- Training responsibilities
- Provision of 24-hour nursing
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**
Written Agreement

General Overview
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.

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
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.

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.
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

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)
2022 Top Findings in HSRF

<table>
<thead>
<tr>
<th>Standard</th>
<th>Content</th>
<th>CMS Tag</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSRF 6.I</td>
<td>Hospice plan of care present/coordination occurs with facility (56%)</td>
<td>L 774</td>
</tr>
<tr>
<td>HSRF 9.I</td>
<td>Clinical record required components (38%)</td>
<td>L781</td>
</tr>
</tbody>
</table>

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
Hospice Leadership and Governance

HSLG

HSLG 2.1 - 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
HSLG 3.I - 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

HSLG 5-6 - 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
HSLG 7.1 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

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.
**HSLG 9.I-10.I 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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**HSLG 11-13.I**

**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
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

HSLG 17-18.I
Multiple Locations

- Complies with federal regulation regarding disclosure of ownership and control information
- Ensures hospice multiple locations are approved by Medicare and licensed as appropriate before providing care
- Clearly delineates lines of authority
- Shares administration, supervision and services with parent

Hospice monitors and manages all services provided at multiple locations
2022 Top Finding in HSLG

<table>
<thead>
<tr>
<th>Standard</th>
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</tr>
</thead>
<tbody>
<tr>
<td>HSLG 2.I</td>
<td>Governance assumes full authority (36%)</td>
<td>L574,L651</td>
</tr>
<tr>
<td>HSLG 14.D</td>
<td>Required elements of written agreement to furnish services (21%)</td>
<td>L 655</td>
</tr>
<tr>
<td>HSLG 3.I</td>
<td>Qualified administrator and alternate is appointed (14%)</td>
<td>L651</td>
</tr>
</tbody>
</table>

Tips for Success

- Ensure oversight of the volunteer program
- Schedule meetings for the year for finance, QAPI and so on
- Audit agreements and compliance with the elements routinely
Hospice Information Management

HSIM
Standard Summary

Submitted accurate and timely
HSIM 7.I Discontinuation of operations
HSIM 6.I Record Availability
HSIM 5.I Protection

HSIM 1.D Policies and Procedures
HSIM 2.I Standardized Formats
HSIM 3.I Required elements of the clinical record
HSIM 4.I Entry requirements

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
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

Notification of Non-Covered Items

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

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

**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.
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.

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

Source: https://www.palmettogba.com/palmetto/jmhhh.nsf/DIDC/2IBJVIEPSW~Hospice
### 2022 Top Finding in HSIM

<table>
<thead>
<tr>
<th>Standard</th>
<th>Content</th>
<th>CMS Tag</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSIM 4.I</td>
<td>Record entries are legible, authenticated, and dated (92%)</td>
<td>L 679</td>
</tr>
<tr>
<td>HSIM 2.I</td>
<td>Standardized formats, data elements. “Do Not Use” list (6%)</td>
<td>NA</td>
</tr>
<tr>
<td>HSIM 3.I</td>
<td>Elements of the clinical record (2%)</td>
<td>L 678, L 673</td>
</tr>
</tbody>
</table>

### Top Finding

**HSIM 3.I - Elements of the clinical record**

- **L 678** - §418.104(a)(7) physician orders

- **L 673** - §418.104(a)(2) Signed copies of the notice of patient rights in accordance with §418.52 and election statement in accordance with §418.24.
Tips for Success

- Conduct record review
- Template for review of narrative
- Provide staff with “do not use” listing as a job aide
- Address untimely documentation submission
- Template for review of all elements of CTI

Participant Guide
Page 32
CMS Revised Survey Process

Resource

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

(Rev. 2/19, 02-01-21)

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
Survey Tasks

1. Task 1: Pre-survey Preparation
2. Task 2: Entrance Conference
3. Task 3: Sample Selection
4. Task 4: Information Gathering
5. Task 5: Information Analysis
6. Task 6: Exit Conference
7. Task 7: Post Survey Activities

Four Core Conditions of Participation

- §418.52 Patient Rights
- §418.54 Initial and Comprehensive Assessment of Patients
- §418.56 Interdisciplinary Group, Care Planning, and Coordination of Services
- §418.58 Quality Assessment And Performance Improvement
Phase 1 Example

Surveyor will review three core CoPs and six associated CoPs

Three core CoPs:
1. §418.52 Condition of Participation: Patient’s Rights
2. §418.54 Condition of Participation: Initial and Comprehensive Assessment of the Patient
3. §418.56 Condition of Participation: Interdisciplinary Group, Care Planning, and Coordination of Services

Six associated CoPs:
1. §418.52 Condition of participation: Patient’s rights
2. §418.76 Condition of Participation: Hospice Aide and Homemaker Services
3. §418.102 Condition of Participation: Medical Director
4. §418.108 Condition of Participation: Short-term Inpatient Care
5. §418.110 Condition of Participation: Hospices that Provide Inpatient Care Directly
6. §418.112 Condition of Participation: Hospices that Provide Hospice Care to Residents of a SNF/NF or ICF/IID

Phase 2 Example

Surveyor will review §418.58 and 13 associated CoPs

Core CoP:
§418.58 Condition of Participation: Quality Assessment and Performance Improvement

13 associated CoPs:
1. §418.62 Condition of Participation: Licensed Professional Services
2. §418.64 Condition of Participation: Core Services
3. §418.66 Condition of Participation: Nursing Services Waiver Of Requirement That Substantially All Nursing Services Be Routinely Provided Directly by a Hospice
4. §418.70 Condition of Participation: Furnishing of Non-core Services
5. §418.72 Condition of Participation: Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP)
6. §418.74 Waiver of Requirement-Physical Therapy, Occupational Therapy, Speech Language Pathology and Dietary Counseling
7. §418.78 Condition of participation: Volunteers
8. §418.100 Condition of Participation: Organization and Administration of Services
9. §418.104 Condition of participation: Clinical Records
10. §418.106 Condition of Participation: Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment
11. §418.113 Condition of participation: Emergency preparedness
12. §418.114 Condition of Participation: Personnel Qualifications
13. §418.116 Condition of Participation: Compliance with Federal, State, and Local Laws and Regulations Related to the Health and Safety of Patients
**Enhanced Hospice Oversight**

CMS announces enhanced oversight for New Hospices:

**Who:**
- newly enrolled as of July 13, 2023
- Final approval for Medicare enrollment on or after July 13, 2023
- Started enrollment prior to July 13, 2023, and have not yet received final approval
- Change of ownership under 42 CFR 489.18
  - Approval on change of ownership on or after July 13, 2023
- Undergoing a 100% ownership change that does not fall under 42 CFR 489.18

**Where:**
Arizona, California, Nevada, and Texas

**When:**
July 13, 2023, for a period of 30 days up to a year

**Why:**
Due to numerous reports of hospice fraud, waste, and abuse. Number of hospices increased significantly in these states raising concerns about market saturation
Contact

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202-218-3700
thank you!