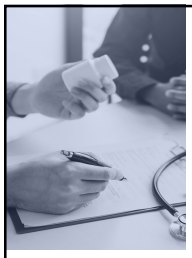
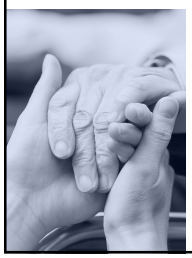


Hospice Consultant Certification

An Interactive Virtual Training



Bobbie Warner RN, BSN
Director of Education
Linda Lockhart

CHAP Community Health Accreditation Partner

1

Name – State – Fun Fact

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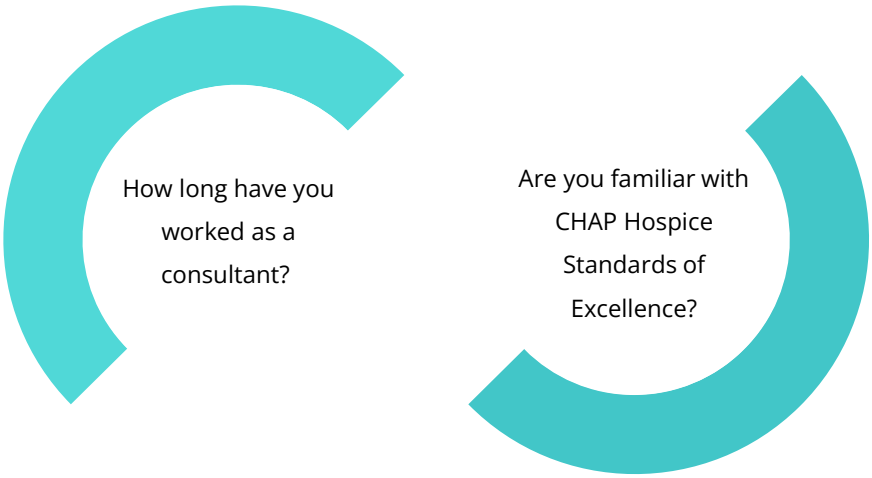
2

Get to Know You Using Microsoft Polls



3

Housekeeping

- Introductions

Agenda and Handouts

- Muting
- Use of Chat
- Raise of hand

4

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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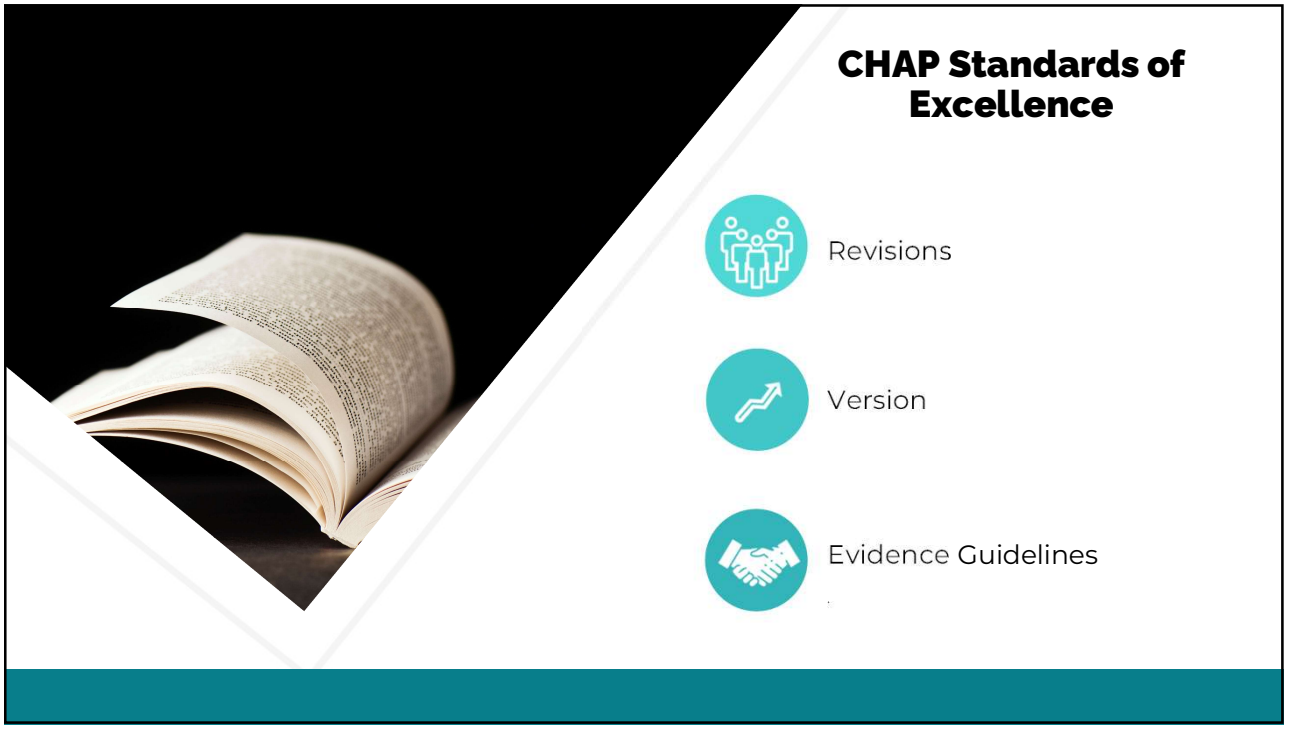

6

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
- https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Electronic-Mailing-Lists

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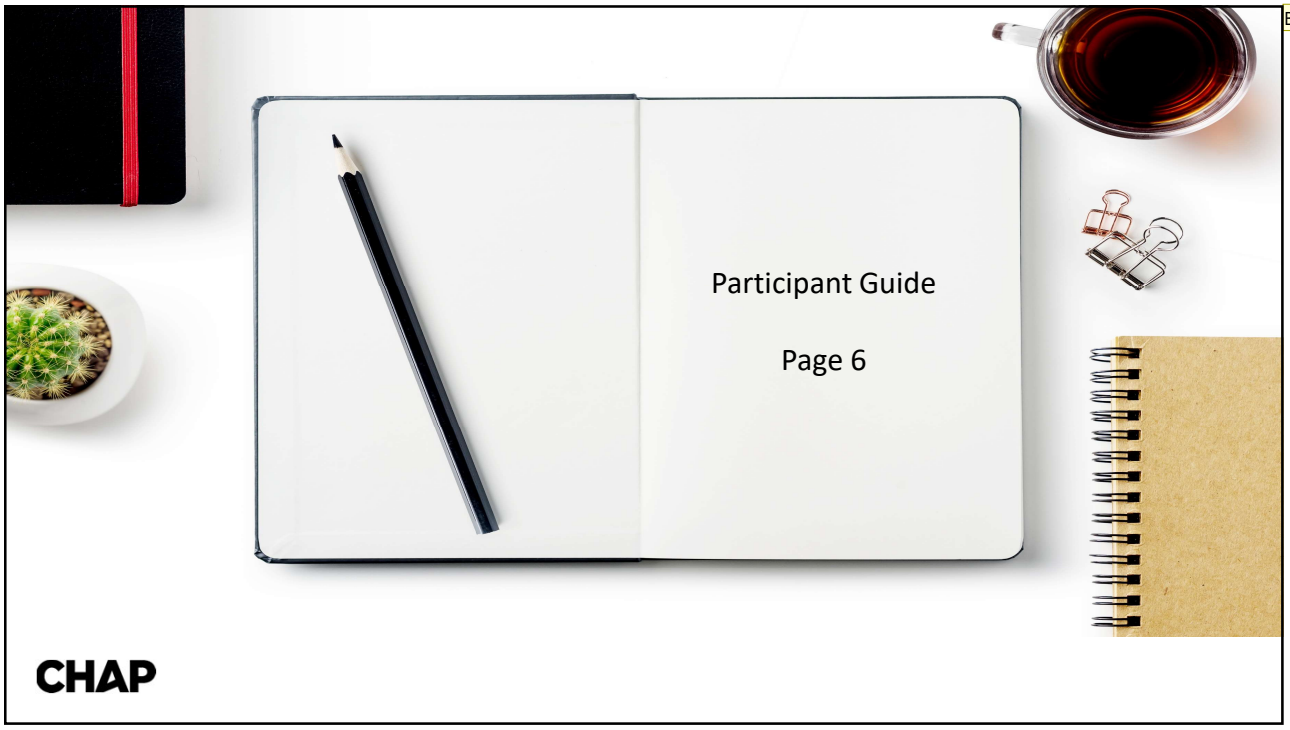

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Slide 8

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Hospice Inpatient Care (HSIC)

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9

Standard Review (1)

HSIC1.I – 4.I General inpatient standards

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

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Standard Review (2)

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

- Hospice responsibilities
- Facility responsibilities

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11

Agreement Requirements

Hospice:

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

Inpatient Provider:

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

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Standard Review (3)

HSIC 6.I –34.I Direct owned IPU

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

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Standard Review (4)

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

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

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Direct or Under Arrangement

Under Arrangement

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

Direct

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

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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

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Ms. Iris

CHAP

17

Iris's pain management

8

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

She lives with her husband of 49 years who is somewhat frail but fully involved in her care. No other family is close by although a daughter lives 500 miles away. She is in contact with her mother and father daily by phone.

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

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GIP Decision

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

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

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

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Thoughts to Consider

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?

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2022 Top Findings in HSIC

Standard	Content	CMS Tag
HSIC 28.I	Preparation/delivery/storage of meals (38%)	L736
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%)	L732

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Tips for Success

All agreement elements are present

Review Plan of Care elements

Directly owned
- Plan fire drills
- Mock survey of LSC
- Life Safety Code addressed through quality program

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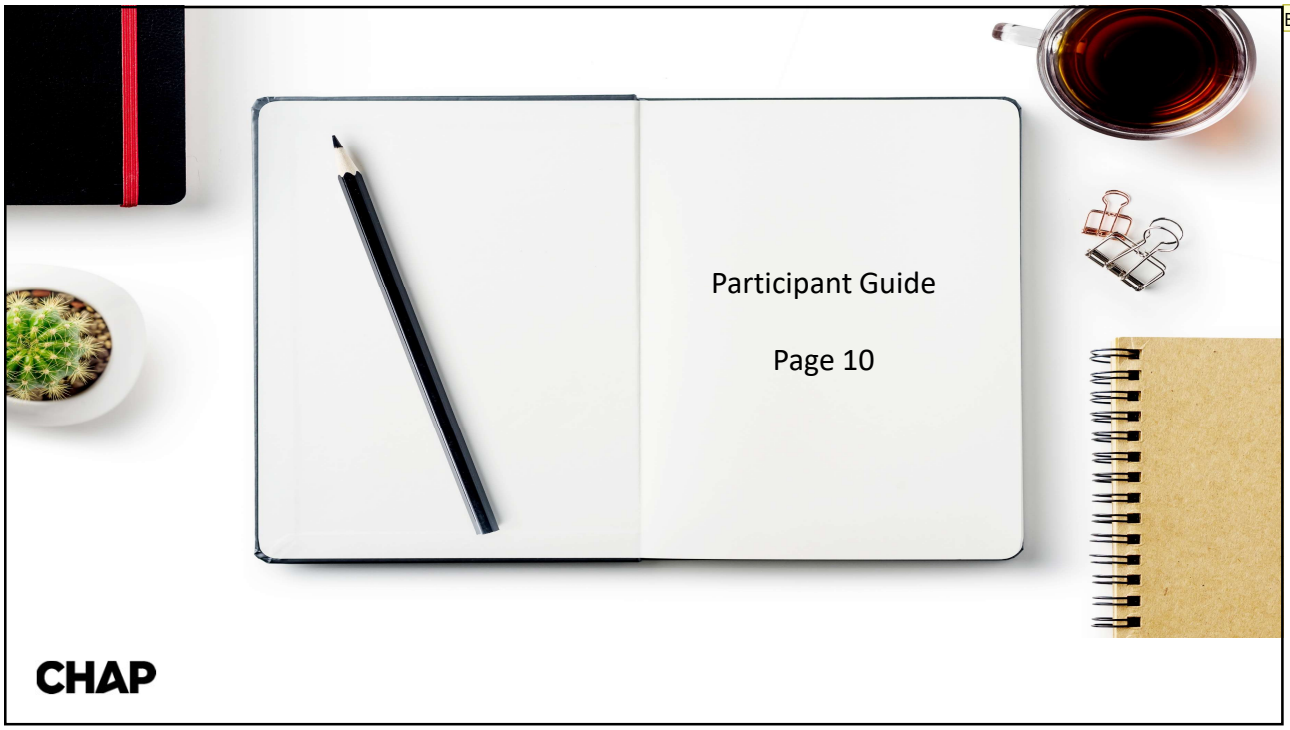

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Hospice Care to Residents in a Facility HSRF

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Slide 23

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HSIC and HSRF

Similarities

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

Differences

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

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When poll is active, respond at **pollev.com/chapinc2**
Text **CHAPINC2** to **22333** once to join

What percentage of organizations that you work with provide care to facility residents?

0%
25%
50%
75%
100%

Start the presentation to see live content. For screen share software, share the entire screen. Get help at **pollev.com/app**

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Hospice Responsibilities

Assessment
Initial and ongoing

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

Care Provision
Professional Staff
Aide Services

Financial Management

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

Determining the Level of Care

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Written Agreement

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.

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Written Agreement

Hospice Responsibilities elements:

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

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Written Agreement

Facility Responsibility elements:

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

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Whose Responsibility

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

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Whose Responsibility?

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

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Yes, or No?

Hospice:

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

Facility:

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

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2022 Top Findings in HSRF

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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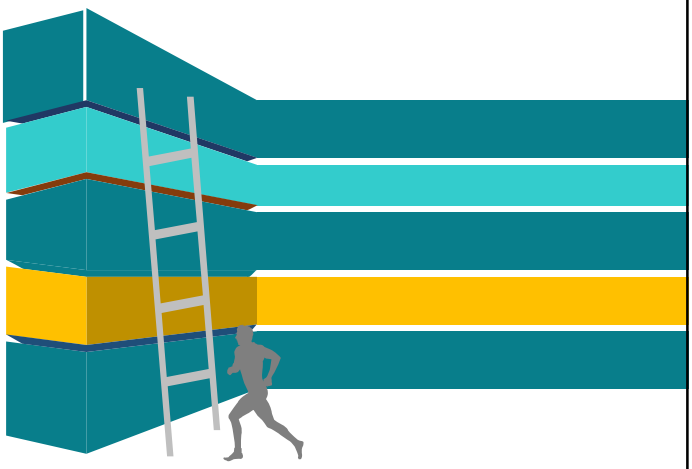
Tips for Success

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



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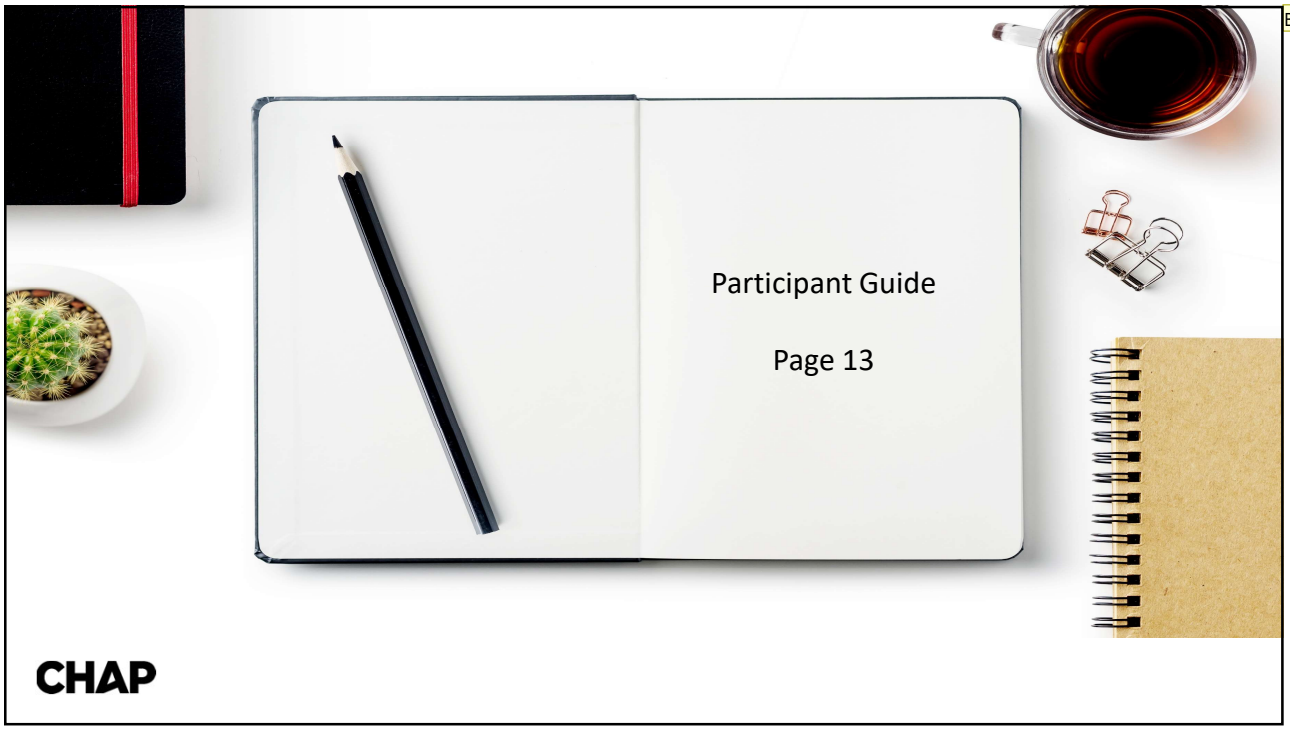
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Hospice Assessment, Care Planning and Coordination
HCPC

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Slide 37

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HCPC 1.I-3.I

Interdisciplinary Group

Composition

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

Role

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

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HCPC 4.I-6.I

Hospice Admission Requirements

Initial determination of anticipated life expectancy of six months or less

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

Recertification

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

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HCPC 7.I-17.I

Timeframes

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

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

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

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

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Comprehensive Assessment Elements

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

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HCPC 11.I – HCPC 16.I

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Scenario

Ms. Iris is being discharged from the skilled facility to return home. Her daughter has arrived, and a meeting has occurred with the family, physician, and IDT to validate the ability of the daughter and spouse to work together to handle the care of the mother. Ms. Iris arrives at home and the hospice team makes plans for assessment and development of the plan of care. Due to staffing circumstances a new employee, an RN new to hospice is scheduled to conduct the assessment. As the consultant, you are reviewing the admission documentation for compliance.

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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 15-17
    - 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
  - Each group assigns one spokesperson to share their thoughts.

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Patient: Iris Wood
SOC: 9/1/2021
Diagnosis – Pancreatic Cancer with metastasis
Secondary – Congestive Heart Failure
Election of benefit signed 8/30/2021
Discharge – Hospital on 8/31/2021
Level of Care: Routine Hospice Care
Age: 70
Advance Directives – Yes

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

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

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HCPC 12.I – Pain Assessment

18

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

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

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

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

Goals for pain management – patient and family

Satisfaction with the current level of pain control.

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

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

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

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

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

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

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

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

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

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

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

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

Endocrine
No issues

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

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

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HCDT 9.I – Social Work Assessment

18

Assessment includes:

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

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50

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

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

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

Endocrine
No issues

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

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

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51

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.

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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

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

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Interdisciplinary Group

HCPC 18.I

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

HCPC 19.I

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

HCPC 20.I

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

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Interdisciplinary Group Involvement

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

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Plan of Care Elements

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

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Individual Activity

- Participants will review the Plan of Care in their participant guide on pages 19-20 to evaluate the abilities of the clinician to develop a comprehensive Plan of Care.
- The activity will be allowed 10 minutes
- Discussion will follow related to the comprehensive nature of the plan of care

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Discussion

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

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

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

SPECIFIC PHYSICIAN ORDERS AS FOLLOWS:

OXYGEN 2 LITERS VIA NASAL CANNULA CONTINUOUS.

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

Routine comfort pack

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

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

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HCPC 23 - Coordination

IDG is responsible for directing, coordinating and supervising care

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

Care and services are based upon all assessments

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

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

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2022 Top Findings in HCPC

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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Top Findings in HCPC

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

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

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

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

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

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Top Findings in HCPC

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

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

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

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

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Top Findings in HCPC

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.*

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Tips for Success

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

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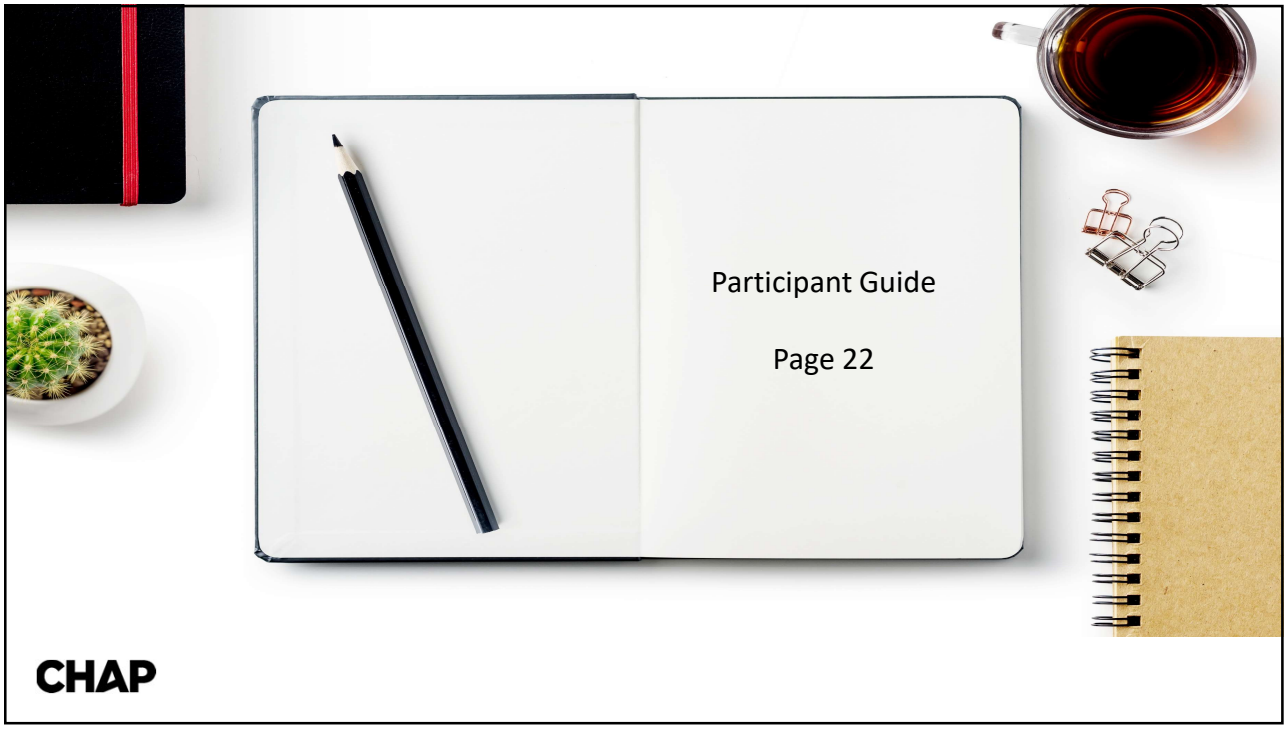
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Hospice Care Delivery and Treatment
HCDT

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HCDT Standard Summary

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

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Provision of all Services

HCDT.5-12.I

Core Services

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

HCDT.13-21

Non-Core Services

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

Requirements

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

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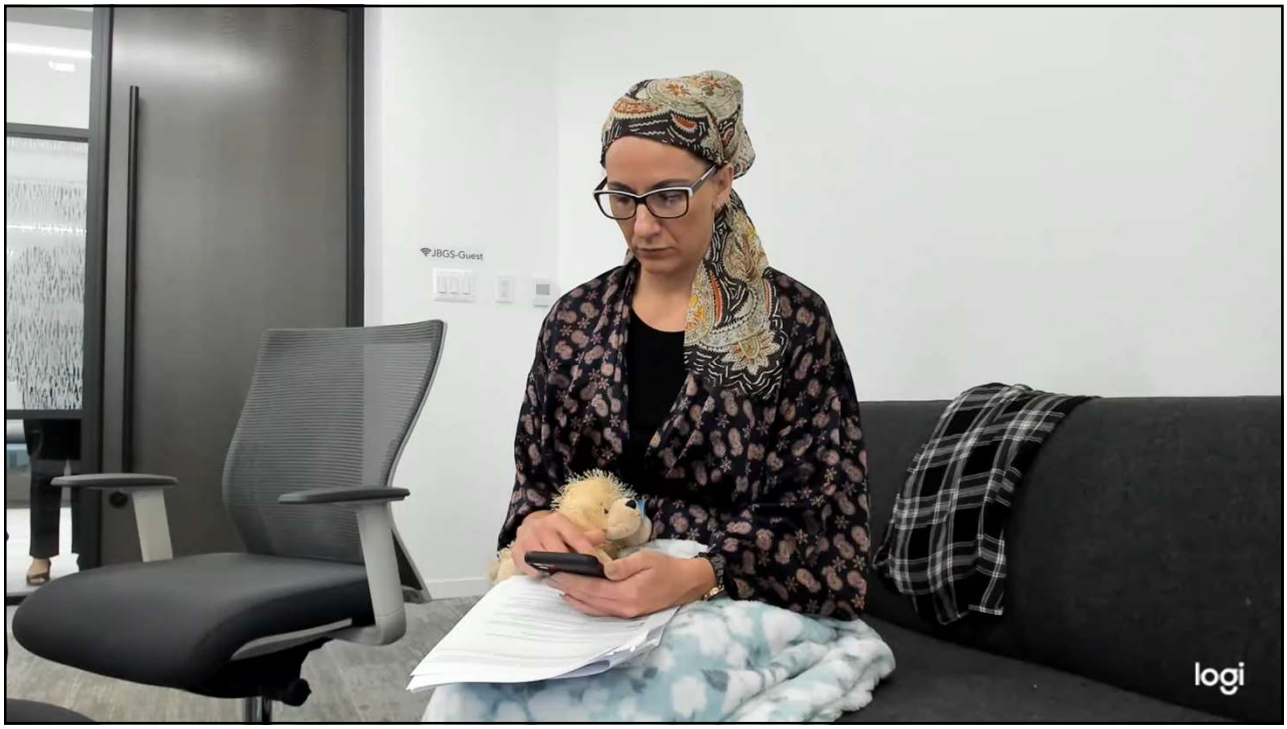

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Discussion

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Interdisciplinary Team Meeting

Review the IDT note from the first meeting held after the visit observed with Ms. Iris (pages 23-25)

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

Prepare for a robust discussion

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Discussion

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

Date of Meeting: 10/14/2021

Problem overview:

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

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

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

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

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

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

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

Recommendations: Orders as follows:

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

Signed: Marcus Welby MD

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2022 Top Findings in HCDT

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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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

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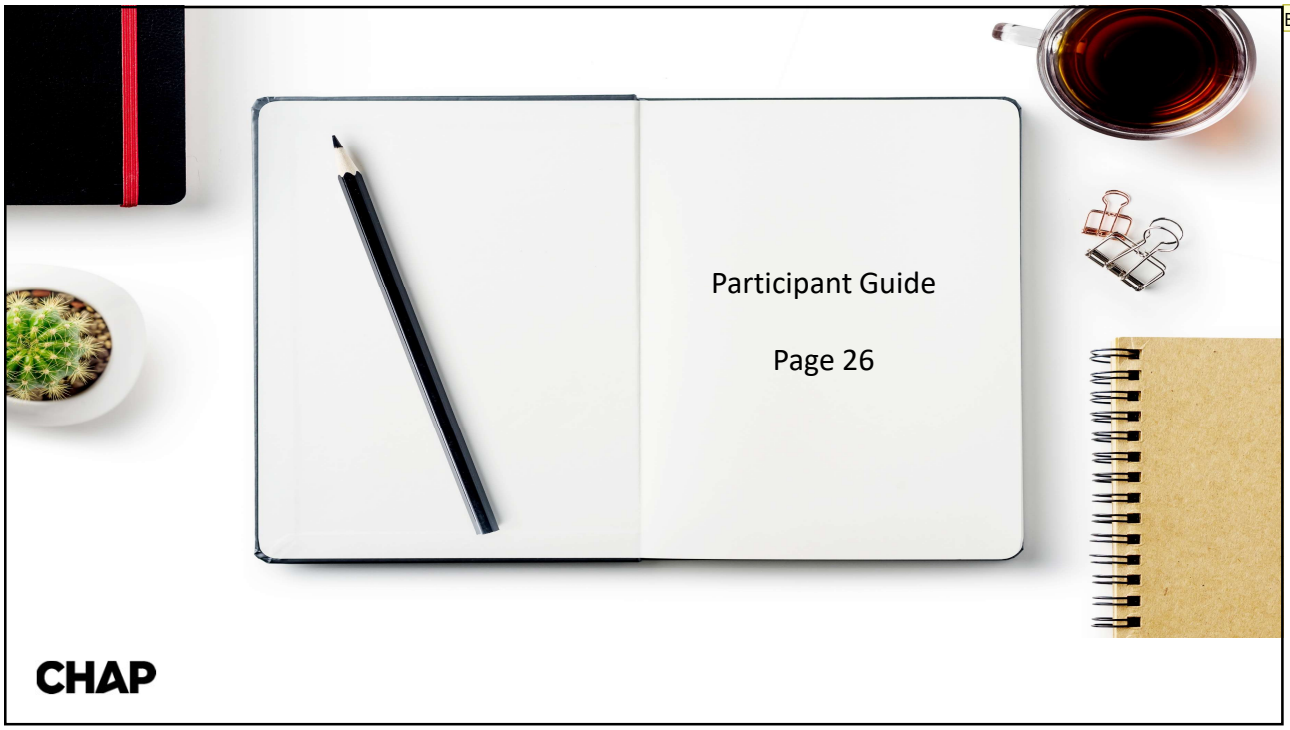
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Hospice Leadership and Governance
HSLG

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Slide 85

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HSLG 2.I - Governance

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

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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

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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

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HSLG 7.I Volunteers

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

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HSLG 8.I 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 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

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HSLG 14.D – 16.D
Agreements

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

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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

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2022 Top Finding in HSLG

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

- 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

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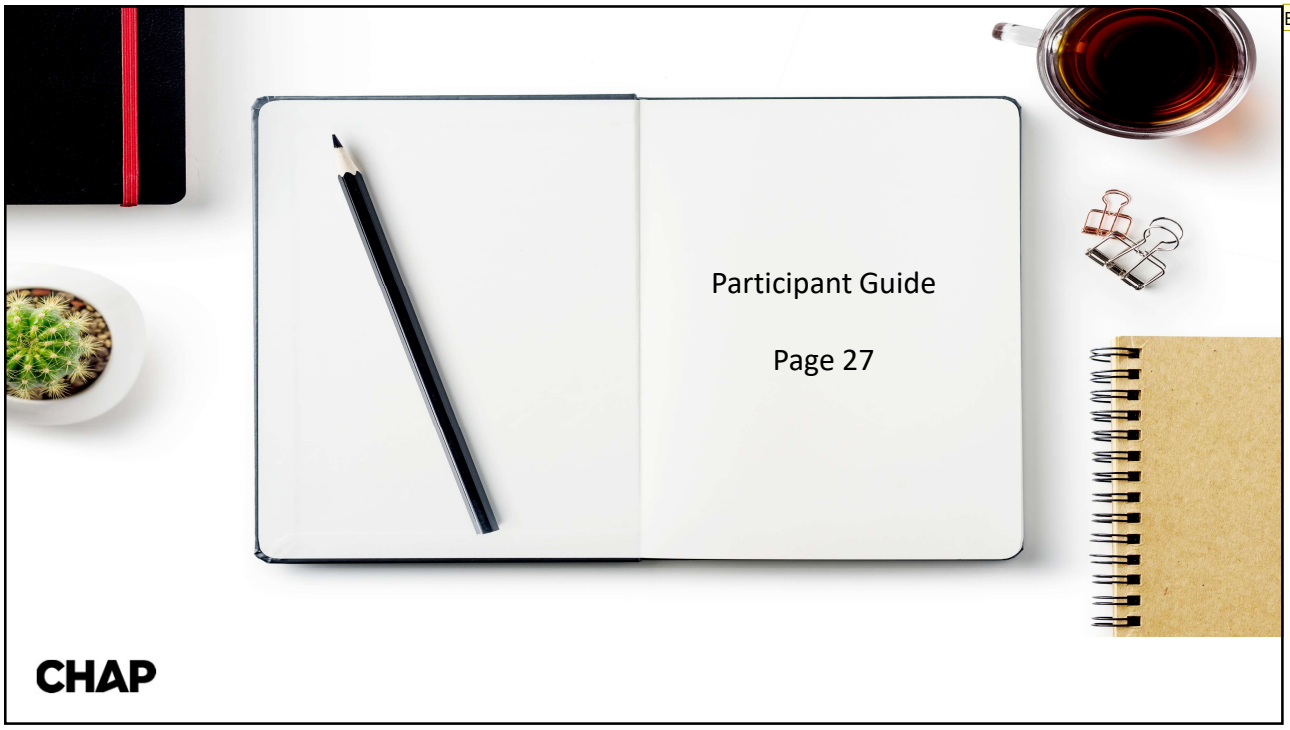

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Hospice Patient/Family Centered Care (HPFC)

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Elements of the Patient Bill of Rights

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

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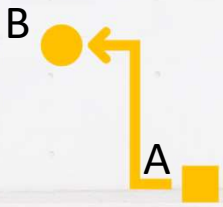
Implementation of Patient Rights

Complaint Process

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



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2022 Top Findings in HPFC

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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Top Findings in HPFC

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

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

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

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

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Tips for Success

Documentation of advance directive conversation

Review documents for completion

Teach staff to complete all information gained on admission

Checklist for admission elements

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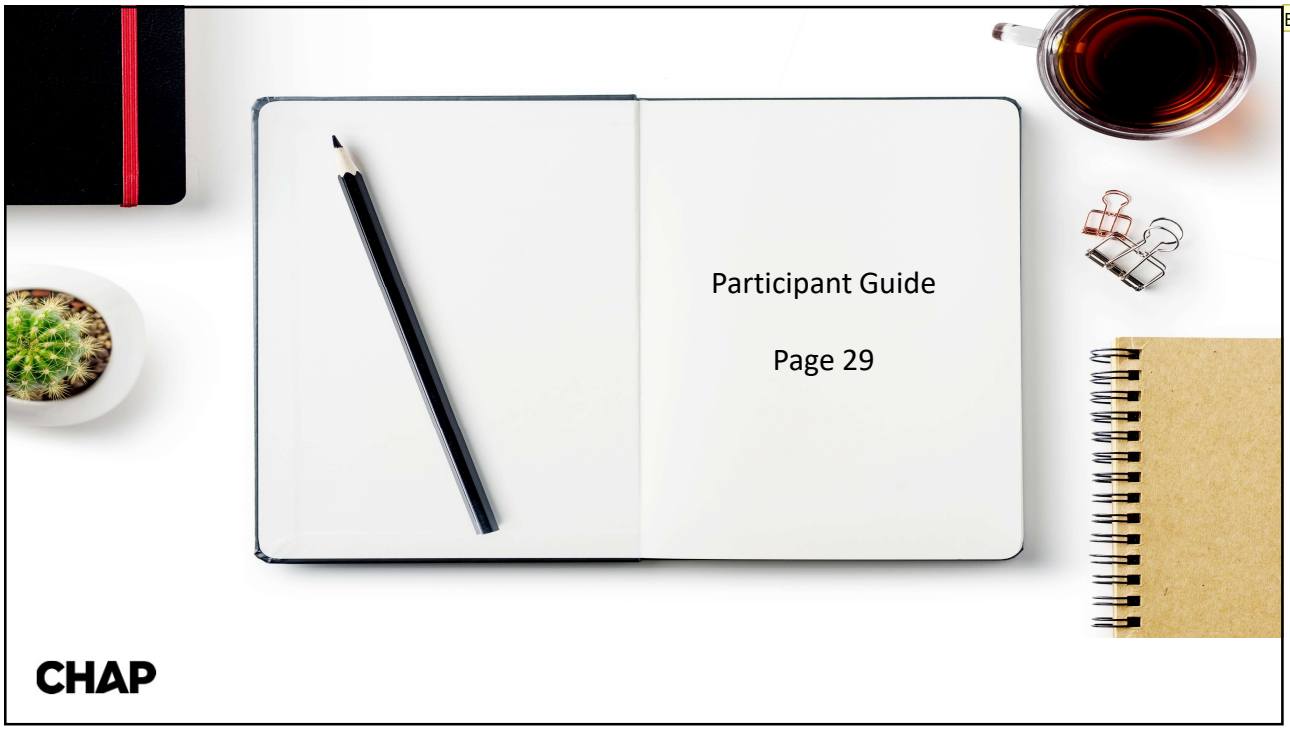
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Hospice Information Management
HSIM

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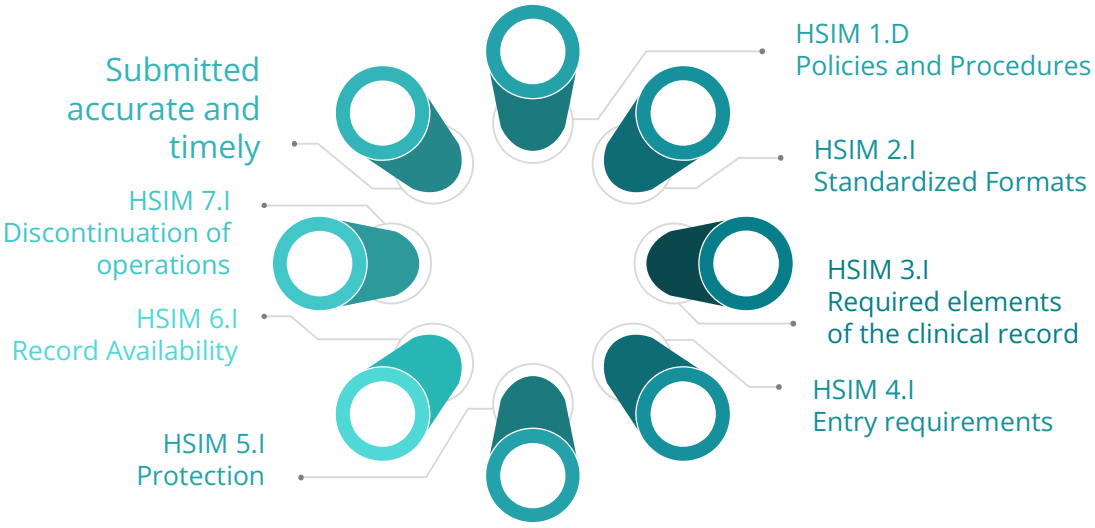
Standard Summary



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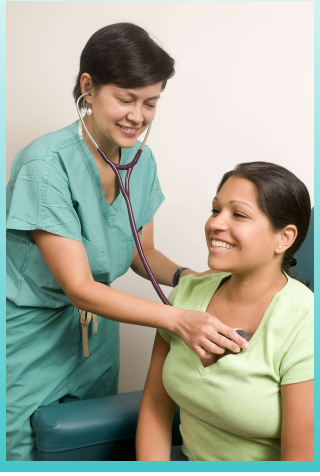
Clinical Record Elements

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



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

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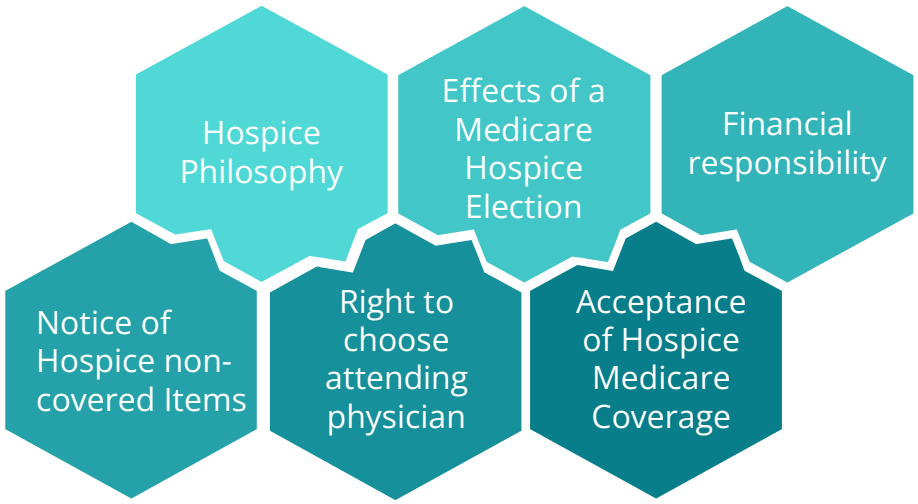
Election of Benefit

Information to be provided to the patient



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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

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

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Certification of Terminal Illness

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

- Written must be signed and dated prior to billing Medicare

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

Certifying Physician only

Contents

- Medical prognosis
- Narrative
- The benefit period dates

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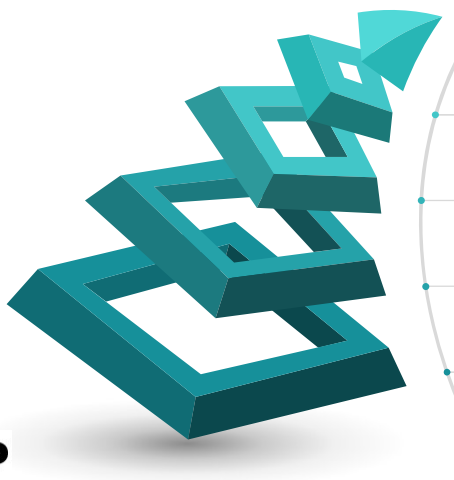
Narrative



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

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Face to Face Encounter

Third benefit period and subsequent:

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

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Common Errors

Narrative

- missing
- No attestation statement

Verbal Certification

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

Signature and date

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

Certification Dates

- Not clearly stated

Source: https://www.palmettogba.com/palmetto/jmhhh.nsf/DIDC/2IBJVJEP5W~Hospice

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2022 Top Finding in HSIM

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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Top Finding

HSIM 3.I - Elements of the clinical record

L678 –§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.

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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

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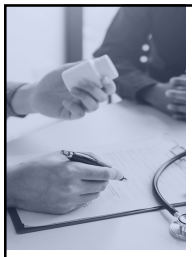
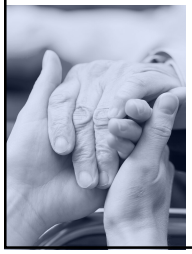


CMS Revised Survey Process



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Resource

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

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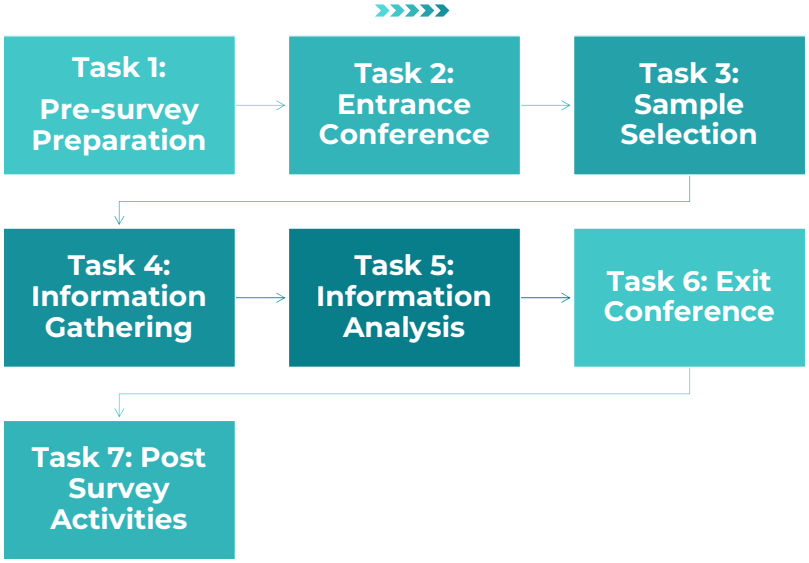
Survey Tasks



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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

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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

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What was today's valuable lesson? (page 30)

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