Objectives

- Describe best practices for documenting requirements of the initial and comprehensive assessment of the patient.
- Describe the role of the Interdisciplinary group, best practices for care planning and coordinating services.
- Describe the elements necessary to develop and maintain an effective quality assessment and performance improvement program.
- Describe components of electronic documentation that are conducive to best practices in hospice documentation.

Initial Assessment 418.54 (a)

“The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with 418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)
Initial Assessment

- Completed by RN
- Within 48 hours after election
- Must take place in location where hospice services are being delivered
- Gather critical information to treat pt/family's immediate care needs
- Essential info necessary to begin the plan of care

Comprehensive Assessment 418.54

“The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient’s need for hospice care and services, and the patient’s need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.”

Timeframe for Completion 418.54(b)

“The hospice interdisciplinary group, in consultation with the individual’s attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with 418.24.”
Compliance 418.54(b)

- Ensure that the IDG staff understand the process for completion of the comprehensive assessment.
- Have a process for assessment if a member of the IDG is refused.
- If the comprehensive assessment is in multiple forms, develop a tracking process to ensure completion within the required time frame.
- Comprehensive assessment must be readily identifiable in the clinical record.

Comprehensive Assessment

- Patient specific
- Identifies patient’s need for hospice care
- Palliation and management of terminal illness and related conditions
- Completed by the interdisciplinary group, in consultation with attending physician
- Must be completed no later than 5 calendar days from election

Update of the Comprehensive Assessment 418.54(d)

“The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual’s attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient’s progress toward desired outcomes, as well as a reassessment of the patient’s response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.”
Update of the Comprehensive Assessment 418.54(d)

- In collaboration with the Attending Physician, if any
- Changes that have taken place
- Progress toward outcomes
- Reassessment of the patient’s response to care
- At least every 15 days

Best Practice Examples

- LCD’s are utilized as guidelines to verify hospice eligibility
- Hospice services are available twenty-four (24) hours a day, seven (7) days a week
- RN consults with other team members after initial assessment to begin developing the plan of care

Contents of the Comprehensive Assessment 418.54(c)

“The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient’s well-being, comfort, and dignity throughout the dying process.”
Content of the Comprehensive Assessment 418.54(c)(1)-(6), cont.

- The comprehensive assessment must take into consideration the following factors:
  - The nature and condition causing admission
  - Complications and risk factors that affect care planning
  - Functional status, including the patient's ability to understand and participate in his or her own care.

Content of the Comprehensive Assessment 418.54(c)(1)-(6), cont.

- Imminence of death
- Severity of symptoms
- Drug profile Review
  - All prescription and OTC drugs, herbs and alternate treatments that could affect drug therapy
  - Effectiveness of drug therapy
  - Drug side effects
  - Actual or potential drug interactions

Content of the Comprehensive Assessment 418.54(c)(1)-(6)(8), cont.

- Duplicate drug therapy
- Drug therapy currently associated with laboratory monitoring
- "The need for referrals and further evaluation by appropriate health professionals," 418.54(c)(8)
Compliance 418.54(c)(6)

• Review of drug profiles by an individual with education and training in drug management.
• Make sure the medication profile is always up to date.
• Make sure the assessment of medication is a mandatory question at every visit in your software.
• Audit medical records to make sure that each patient’s comprehensive assessment includes an accurate drug profile.

Bereavement 418.54(c)(7)

“An initial bereavement assessment of the needs of the patient’s family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient’s death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.”

Patient Outcome Measures 418.54(e)(1)

“The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.”
“The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice’s quality assessment and performance improvement program.”

“The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services.”

Duties of the Interdisciplinary Group

- Work together to meet physical, medical, psychosocial, emotional and spiritual needs of the patient and family
- Provide care and services
- Supervise care and services
- Designate RN to coordinate care and ensure continuous assessment of each patient and family’s needs.
Composition of IDG 418.56(a)(1)

“The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:

• A doctor of medicine or osteopathy (who is an employee or under contract with the hospice)
• A registered nurse
• A social worker
• A pastoral or other counselor

418.56 Interdisciplinary Group, Care Planning, and Coordination of Services

“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.”

Plan of Care 418.56(b)

“All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient’s needs if any of them so desire.”
Compliance 418.56(b)

• Ensure that all members of the IDG have access to the patient’s current plan of care and that the plan of care is updated.
• Ensure that the team members visit the patient/family according to the frequency established on the plan of care.
• Ensure that the team documents why the visit frequency on the patient’s plan of care was not followed, or need for a change in frequency or extra visits
• Document all care plan updates!
• Audit, Audit, Audit!

Plan of Care 418.56(b)

• Individualized
• Established by the Interdisciplinary Group
• In collaboration with the Attending Physician, if any
• In collaboration with the patient, or representative and primary caregiver
• Needs based on Comprehensive Assessment
• All hospice care and services furnished must follow the Plan of Care
• Must be reviewed by the Interdisciplinary Team at least every 15 days

Content of Plan of Care 418.56(c)(1)-(6)

“The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:”
Content of Plan of Care, cont.

- Interventions to manage pain and symptoms
- A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.
- Measurable outcomes anticipated from implementing and coordinating the plan of care.
- Drugs and treatment necessary to meet the needs of the patient.

Content of Plan of Care, cont.

- Medical supplies and appliances necessary to meet the needs of the patient.
- The interdisciplinary group’s documentation of the patient’s or representative’s level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice’s own policies, in the clinical record.

Compliance 418.56(c)

- Ensure that all problems identified during assessment are included on the patient’s plan of care.
- Updates to comprehensive assessments should be reflected in the plan of care.
- Avoid canned phrases – make sure interventions and goals are individualized and patient specific.
- Be consistent in assessment, provision of care, and follow-up.
- Audits – compare care to plan of care.
Facility Care 418.112(d)

“In accordance with 418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this hospice plan of care. The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.”

418.112(d)(2)(3)

“The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the extent possible. Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/MR representatives, and must be approved by the hospice before implementation.”

POC for Facility Patients

- Developed in consultation with facility reps
- Care provided is in accordance with poc
- POC must identify which provider is responsible for performing functions
- POC reflects participation of hospice, facility, pt/family, to extent possible
- Changes to POC discussed with pt/rep and facility rep
- Must be approved by hospice before implementation
Best Practice Examples

• Ongoing assessment occurs during any contact or interaction related to the patient and the plan of care is amended accordingly.

• Significant changes to assessments are immediately shared with other team members.

• Frequency of visits performed by the interdisciplinary team members are in accordance with the visit frequency stated in the plan of care.

• Proactively anticipate potential medication side-effects and implement preventive measures.

Best Practices, cont.

• Attending physician is invited to attend team meetings when the patient will be discussed.

• The hospice nurse or other members of the IDT, at patient’s request, regularly communicate with family members.

• Use of accepted professional standards of practice in management of patient’s symptoms such as pain, nausea, vomiting, dehydration, constipation, dyspnea, emotional distress, insomnia, spiritual needs.

Review of the Plan of Care 418.56(d)

“The hospice interdisciplinary group (in collaboration with the individual’s attending physician, if any) must review, revise and document the individualized plan as frequently as the patient’s condition requires, but no less frequently than every 15 calendar days. A revised plan of care must include information from the patient’s updated comprehensive assessment and must note the patient’s progress toward outcomes and goals specified in the plan of care.”
Compliance 418.56(d)

- Document the review of the plan of care as the patient’s condition requires but at least every 15 days.
- Ensure that the IDG is communicating and collaborating continuously and documenting it.
- Ensure that the patient, cg/family are included in the process to update the plan of care.
- Audit clinical records to assess compliance with 15 day review.

It starts with a “winning care plan”

Coordination of Services 418.56(e)

“The hospice must develop and maintain a system of communication and integration, in accordance with the hospice’s own policies and procedures, to:
- Ensure that the IDG maintains responsibility for directing, coordinating, and supervising the care and services provided.
- Ensure that the care and services are provided in accordance with the plan of care.
- Ensure that the care and services provided are based on all assessments of the patient and family needs.
Coordination of Services, cont.

• Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.
• Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.

Compliance 418.56(e)(2)

• Ensure that all members of the IDG have access to the patient’s current plan of care and that the plan of care is updated.
• Ensure that the patient is receiving the care as stated in the plan of care.
• Ensure that the team members visit the patient/family according to the frequency established on the plan of care.
• Document all care plan updates!
• Audit, Audit, Audit!

Quality Assessment and Performance Improvement 418.58

“The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program... The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.”
The Governing Body’s Role in QAPI 418.58

“The hospice’s governing body must ensure that the program:
• Reflects the complexity of its organization and services;
• involves all hospice services (including those services furnished under contract or arrangement);
• focuses on indicators related to improved palliative outcomes;
• and takes actions to demonstrate improvement in hospice performance.

QAPI Program

• Develop, implement and maintain
• Effective
• Ongoing
• Hospice-wide
• Data-driven
• Involves all hospice services
• Demonstrate improvement in performance
• Documented evidence of the program

QAPI Program

• Fosters the continual striving of improvement within the delivery of care and services
• Fosters a “blame-free” environment
• Focuses on evaluating processes in the hospice instead of fixing one problem at a time
Continuous Performance Improvement

- Continual Assessment
- Implementation of Solutions
- Evaluations to determine how to do even better
- Assessment of Effectiveness of Solutions

Evidence of an Effective, Functioning QAPI Program

- Regular meetings
- Investigation and analysis of sentinel and adverse events
- Recommendations or options for systemic change to prevent recurrence of sentinel or adverse events
- Identified performance measures that are tracked and analyzed
- Regular review and use of the QAPI analyses by hospice management and the governing body to make systemic improvements

Program Scope 418.58(a)

“The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.”
Program Scope 418.58(a)(2)

“The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.”

Program Data 418.58(b)

“The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.”

Best Practices

All patient services and all activities that may impact patient/family care should be evaluated as part of the QAPI program.

- Physician services
- Nursing services
- Medical social services
- Counseling services
- Clinical records
- Infection control
Best Practices

- Pharmaceutical services
- Durable medical equipment
- Patient rights
- Administrative services
- Contract services
- Volunteers
- Hospice Aide
- Adverse Events

Program Data 418.58(b)(2)-(3)

“The hospice must use the data collected to do the following:

- Monitor the effectiveness and safety of services and quality of care.
- Identify opportunities and priorities for improvement.

The frequency and detail of the data collection must be approved by the hospice’s governing body.”

Program Activities 418.58(c)(1)

“The hospice’s performance improvement activities must:

- Focus on high risk, high volume, or problem-prone areas.
- Consider incidence, prevalence, and severity of problems in those areas.
- Affect palliative outcomes, patient safety, and quality of care.”
Adverse Events 418.58(c)(2)

“Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.”

Measurement 418.58(c)(3)

“The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.”

Performance Improvement Projects 418.58(d)-(d)(1)

“Beginning February 2, 2009, hospice must develop, implement and evaluate performance improvement projects. The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice’s population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice’s services and operations.”
Performance Improvement Projects (PIPs) 418.58(d)(2)

“The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.”

Executive Responsibilities 418.58(e)

“The hospice’s governing body is responsible for ensuring the following:

• That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.

• That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.”

Infection Control 418.60

“The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.”
Prevention 418.60(a)

“The hospice must follow accepted standards of practice to prevent the transmission of infectious and communicable diseases, including the use of standard precautions.”

Control 418.60(b)

“The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that—

- Is an integral part of the hospice’s quality assessment and performance improvement program; and
- Includes the following:
  - A method of identifying infectious and communicable disease problems; and
  - A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.”

Education 418.60(c)

“The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.”
Best Practice Examples

• A quality council is established to oversee performance improvement activities with representation from all disciplines.
• Patients are surveyed during the course of care to determine their level of satisfaction with the hospice care received.
• Staff and volunteer surveys
• Bereavement service satisfaction is assessed among those who have participated in bereavement care.

Future Quality Reporting

• Hospice Item Set (HIS)
  » July 1, 2014
  » Data on admission and discharge of every patient
  » Data collection to include information for 7 new quality measures
  » Hospices who fail to report quality data via the HIS system in 2014 will have a 2% market basket reduction for FY2016

NQF Assessment Items

• NQF #1634 Pain Screening
• NQF #1637 Pain Assessment
• NQF #1639 Dyspnea Screening
• NQF #1638 Dyspnea Treatment
• NQF #1617 Patients Treated With an Opioid who are Given a Bowel Regimen
• NQF #1641 Treatment Preferences
• NQF #1647 Beliefs/values addressed
Real Life Performance Improvement Projects

» Antibiotic Usage at End of Life
  • Performance Measure – Infection Reports
  • Analysis – Appropriate use of antibiotics/documentation of symptoms
  • Tracked – quarterly over the course of a year

  Benefits –
  Education regarding appropriate use of antibiotics

Real Life Performance Improvement Projects

• Time of Death Visits
  » Performance Measure – Number of Deaths with no hospice visit
  » Analysis – Deaths where no visit was made/reasons
  » Tracked – ongoing/reported quarterly

  Benefits –
  • Met goal of 99%
  • Improved support at time of death

Real Life Performance Improvement Projects

• Family Evaluation of Hospice Care
  » Performance Measure – FEHC
  » Analysis - “Very Confident” and “Excellent”
  » Tracked – quarterly

  Benefits –
  Improved survey results
  Staff Pride / Morale
Making the PIP Hospice-Wide

- PIP quizzes / tickets in bowl for drawings
- Eye catching posters (made by hospice staff)
- Word Campaign
- Informing all staff of PIP progress and outcomes
- All staff rewards for meeting or sustaining goals
- Cheer Leading!!!

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