Individualizing Hospice Care Plans in a Technological (EMR) World

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Learning Objectives

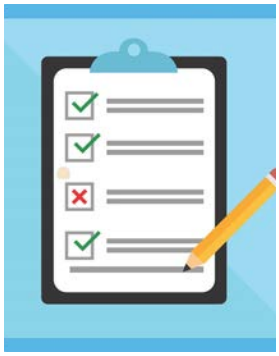
1. Describe potential consequences of poor care planning practices.
2. List the required components of the individualized hospice plan of care.
3. Identify common challenges and potential resolutions associated with the documentation of the individualized hospice plan of care within an electronic medical record.

Importance of the Plan of Care

- The plan of care contains the directions that guide the interdisciplinary group in the care of the terminally ill patient
- Comprehensive and data-driven
- Constantly evolving

Poor Care Planning Practices: Potential Consequences

- Survey-related deficiencies
  - Standard level deficiencies
  - Condition level deficiencies (Reminder – new Special Focus Program considers Condition level deficiencies!)
  - **Immediate Jeopardy**



Poor Care Planning Practices: Payment Denial References

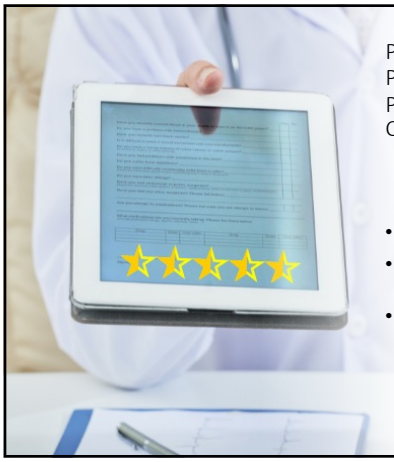
- *"There was no evidence of significant changes to the plan of care."*
- *"The IDG POC revisions were not supported due to a lack of new information and changes to the beneficiary's condition recorded in the documentation."*

Poor Care Planning Practices: Payment Denial References

- *"The IDG meeting notes with the associated POC's were very generalized with little to no new or updated information form one meeting to the next to support review and revision."*

Poor Care Planning Practices: Payment Denial References

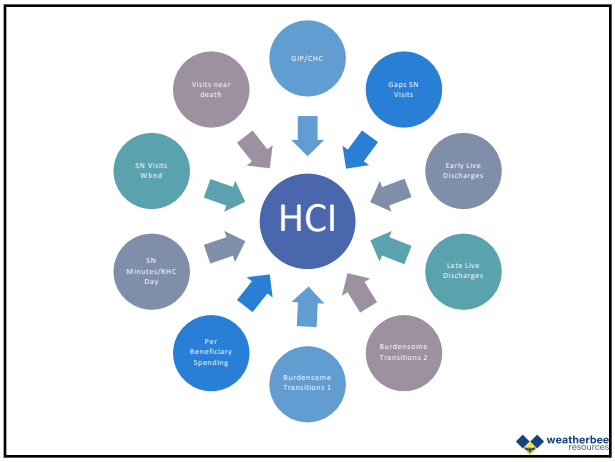
- *"The notes did not support a revised POC with updated information from comprehensive assessment to include the beneficiary's progress towards outcomes and goals."*



Poor Care Planning Practices: Potential Consequences

Unfavorable patient and family outcomes!

- Adverse Events
- Patient/family Complaints
- HQRP
  - ➢CAHPS
  - ➢HVLDL
  - ➢Hospice Care Index



Patterns of Hospice Live Discharges and Transitions

Atypical transition patterns suggest problems in hospices' care processes, advance care planning to prevent hospitalizations, or discharge processes. Revocations may also be related to business practices or quality of care.

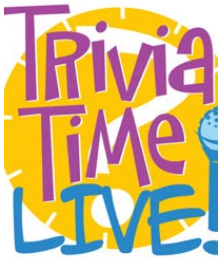
– Hospice Care Index Technical Report

Burdensome Transitions (Type 1)

…burdensome transitions (Type 1), reflects hospice live discharge with a hospital admission within two days of hospice discharge, and then hospice readmission within two days of hospital discharge. This pattern of transitions may lead to fragmented care and may be associated with problematic care processes. For example, burdensome transitions (Type 1) may arise from a deficiency in advance care planning to prevent hospitalizations or a discharge process that does not appropriately identify a hospice patient whose conditions are stabilized prior to discharge.

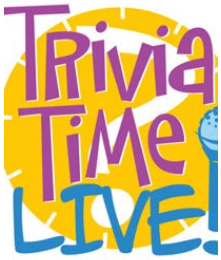
– Hospice Care Index Technical Report

The Individualized Hospice Plan of Care



Where can you find the regulations related to the individualized plan of care?

A) § 418.20
B) § 418.56
C) *Medicare Benefit Policy Manual Chapter 9*
D) The binder in our Compliance Officer's office



True or False

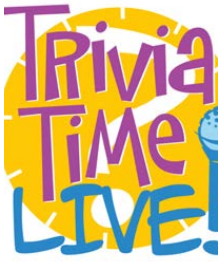
The following is an acceptable goal of care: "The patient will be admitted to Sunshine Hospice in accordance with CMS regulations."

How many types of services must be included in the individualized plan of care?

A) 2
B) 4
C) 6
D) I have no idea

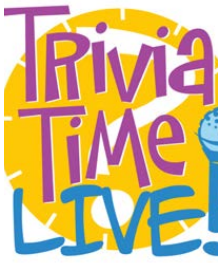
True or False

The IDG must review, revise and document the POC no less than every 14 calendar days.



True or False

It is acceptable for the nursing facility to order antibiotics for a UTI and inform the hospice nurse during the next visit.



True or False

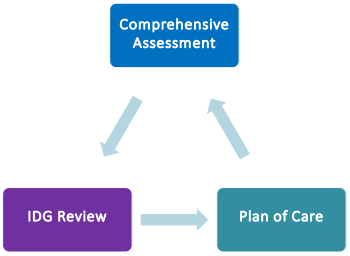
The RN must conduct an "RN Recertification" visit prior to the recertification of terminal illness.

Caution: DO NOT Confuse Regulatory Policy with EMR Functionality

- Know how to access the regulations and regulatory resources.
- Ensure policies, procedures, and documentation protocols are rooted in regulation.
- Recognize EMR requirements ≠ regulation.

"All of these compliance rules and regulations are such a bother. I never thought we actually had to read our policies and procedures."

The Hospice Interdisciplinary Group (IDG) Process



§418.54 Condition of participation: Initial and comprehensive assessment of the patient.

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.

Comprehensive Assessment: Required Elements

1. Nature and condition warranting hospice	2. Complications/Risk Factors	3. Functional Status	4. Imminence of Death
5. Severity of Symptoms	6. Drug Profile	7. Bereavement	8. Need for Referrals

§418.54 Condition of participation: Initial and comprehensive assessment of the patient.

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...

§418.54 Condition of participation: Initial and comprehensive assessment of the patient.

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.

§418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services

- Every patient must be assigned a designated IDG.
- The IDG, with the designated attending physician, must develop a written plan of care (POC).
- The POC must specify the patient and family needs identified in the comprehensive assessments as they relate to the terminal prognosis.

(a) Standard: Approach to Service Delivery.

The designated IDG must include (but is not limited to) the following members:

- Medical Doctor or Doctor of Osteopathy
- Registered Nurse
- Social Worker, marriage and family therapist (MFT) or a mental health counselor (MHC)*
- Pastoral or other counselor

* Hospices are required to have at least one of the 3 practitioners listed (SW, MFT, or MHC) as a member of the IDG; however, a hospice must employ a SW (as the provision of medical social services is a core service)

Additional IDG Members

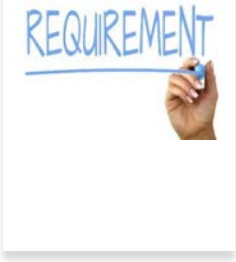
- Triage
- Licensed Vocational Nurse
- Hospice Aide
- Nurse Practitioner
- Bereavement
- Volunteers
- Pharmacist
- Etc.

§418.56 (b) Standard: Plan of Care.

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. The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

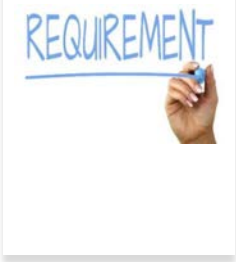
§418.56 (c) Standard: Content of the Plan of Care.

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…



§418.56 (c) Standard: Content of the Plan of Care.

The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:



Direct Link: Comprehensive Assessment & Plan of Care

Comprehensive Assessment Findings

1. Interventions for management of symptoms
2. Visit Frequencies
3. Measurable Outcomes
4. Drugs and treatments
5. Medical supplies and appliances
6. Pt/family understanding/acceptance of Plan of Care

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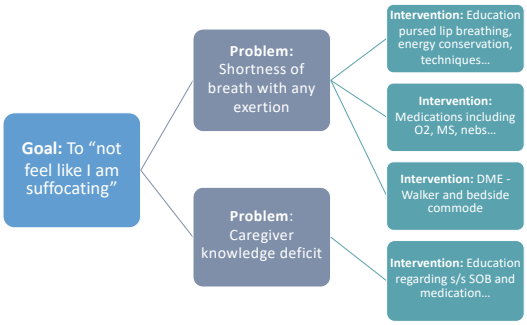
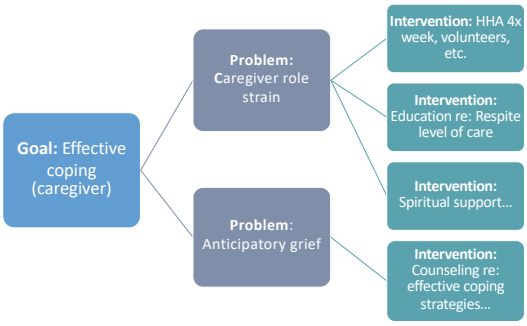
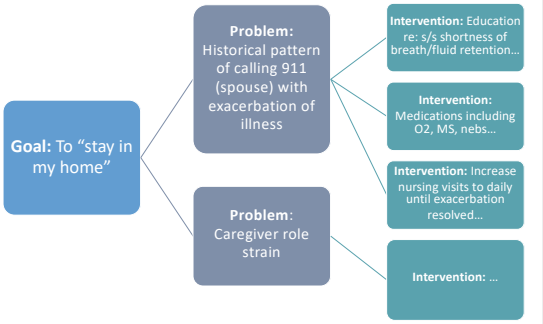
Building the Individualized Plan of Care



Building the Individualized Plan of Care



Building the Individualized Plan of Care



(d) Standard: Review of the Plan of Care.

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.

IDG Meetings: Things to Consider

Is this still the right level of care for the patient (i.e., is hospice the correct service for the patient)?

- LCD guidelines?
- Terminal trajectories of illness?
- Discharge planning?

Reminder: Physician scope of practice ONLY

IDG Meetings: Things to Consider

Is the intent of the IDG mtg being met?

- Are goals of care discussed?
- Progress towards such?
- Complications and risk factors?
- Is anticipatory *planning* occurring?

Effective IDG Meeting: Review Comprehensive Assessment Findings

- Labored breathing/dyspnea any exertion
- Worsening edema BLE and new onset crackles despite increase in diuretic
- Wife tearful during SC telephone call, reports feeling overwhelmed and exhausted.
- 2 calls to Triage past weekend d/t escalating sx/caregiver role strain

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Effective IDG Meeting: Review Comprehensive Assessment Findings

Is Hospice still the appropriate level of care (the physician's decision ONLY)?

- NYHA 4, EF 20%, worsening SOB any exertion, increasing edema despite Lasix
- increasing dependence for ADLs, PPS 50% trending toward 40%
- Etc.

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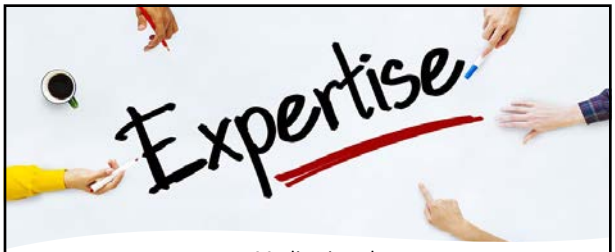
Effective IDG Meeting: Review Progress Towards Goals

GOAL	PROGRESS/PROBLEMS
Management of symptoms in the home	No hospitalizations past 3mo. Increased risk w/ escalating sx, incr caregiver role strain and history 911
Management of dyspnea to tolerable level 2/10	Not met. Pt with dyspnea with any exertion including speaking.
Prevention of fluid retention	Not met. Increase BLE edema from 1+-3+ past week with new onset crackles BLL despite diuretic
Prevention of caregiver role strain.	Not met. Wife tearful and reports feeling overwhelmed and exhausted.



Effective IDG Meeting: Revise POC

- Medication changes
- Education
- Change visit frequencies
- Additional caregiving support
- Counseling/grief support
- Order supplies
- Etc.

Effective IDG Meeting: Revise POC

1. Interventions for management of symptoms
2. Visit Frequencies
3. Measurable Outcomes
4. Drugs and treatments
5. Medical supplies and appliances
6. Pt/family understanding/acceptance of Plan of Care

Increase diuretic. Add nebs. Educate re: use of MS/Ativan SOB/anxiety. Change HA care plan to chair bath versus shower bath. Discuss additional caregiving support options. Should pt enter period of symptomatic crisis, prepare to initiate CHC as warranted (goal to remain at home), etc…

Effective IDG Meeting: Revise POC

1. Interventions for management of symptoms
2. **Visit Frequencies**
3. Measurable Outcomes
4. Drugs and treatments
5. Medical supplies and appliances
6. Pt/family understanding/acceptance of Plan of Care

Increase all IDG visit frequencies d/t s/s possible exacerbation of illness and increasing risk of caregiver breakdown/calling 911. SN to 3x/week, SW and SC to 1x/week and SC to 1x/week. Stagger visits such that an IDG member visit each day (M-F) with SN On-call Visit on weekend days…

Effective IDG Meeting: Document

Document the IDG collaboration:

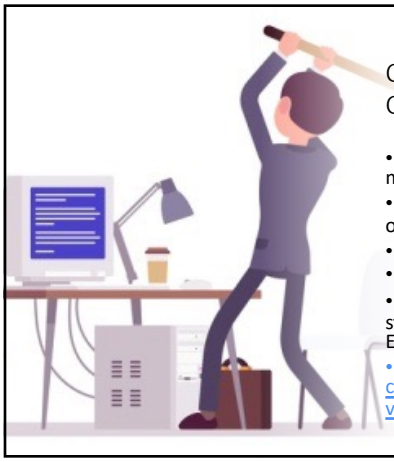
- The *review* of the assessment findings
  - Is hospice still the right level of care?
  - What are the problems?
  - How do these impact the end-of-life goals?
- The *revision* of the POC (i.e., how does the IDG plan to respond following your interdisciplinary review?)

Effective IDG Meeting: Document

Pt with incr BLE edema from 1+ to 3+ and new crackles BLL x 1 week despite Lasix 20mg daily. Noticeably SOB while speaking (SW visit 02/07/24). Lips blue and gasping after 10-minute shower in chair (HA 02/12/24), took 20 min to recover. Wife placed BSC next to bed d/t SOB any exertion. Pt needing assist to stand and, per wife, has been having trouble grasping walker, knees very wobbly. PPS 50% trending toward 40% d/t worsening ability to perform any activity. Wife showing significant caregiver role strain, very tearful when SC called to schedule visit 02/09/24…

Effective IDG Meeting: Document

Increase all IDG visit frequencies in anticipation of exacerbation, increase Lasix to 40mg and educate on MS/Ativan for acute SOB, monitor dizziness/BP, discuss Respite and hiring of private caregivers with wife and son, consider W/C, change to bed bath…



Common EMR Challenges

- The language doesn't match the regulations
- Dropdown menu options only
- Auto-population of data
- Too cumbersome
- Failure to use POC structure provided by the EMR
- The organizational culture does not assign value to the POC!

Strategies to Overcome EMR Challenges

- Know the regulations
- Understand your EMR (including the limitations)
- Print out a plan of care
- Review your policies and documentation protocols

Strategies to Overcome EMR Challenges

- Reach out to your EMR vendor/EMR community for ideas about how to navigate challenges
- Form an action committee (as part of QAPI?) to re-imagine POC documentation protocols as needed
  - ➢Include IDG members

Strategies to Overcome EMR Challenges

- Educate your teams re: the POC (regulations, purpose, consequences of non-compliance) and how to build a POC within your EMR according to your policy and procedures
- Oversight/ongoing coaching as needed

Thank you!

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Click View Product & Fill Out Evaluation.

Certificates are available only after
completing the evaluation.

User Guide available in Links tab or online.

Thank you for joining the webinar today!

Next Quarterly Roundtable is
Wed, Feb 28 at 2pmET
Send your questions to
info@weatherbeeresources.com

The next HCN webinar is Wed, Mar 27 at 2pmET:
"How Will the Shift to Value-Based Care Impact Hospice Access and Quality?"
with Bob Tavares, Chief Commercial Officer
HealthPivots