



## Creating an Effective Hospice Plan of Care



### What's Changed?

No substantive content updates.

The hospice plan of care (POC) maps out needs and services given to a Medicare patient facing a terminal illness, as well as the patient's family or caregiver. CMS data shows that some hospice POCs are incomplete or not followed correctly.

This fact sheet educates on creating and coordinating successful hospice POCs.

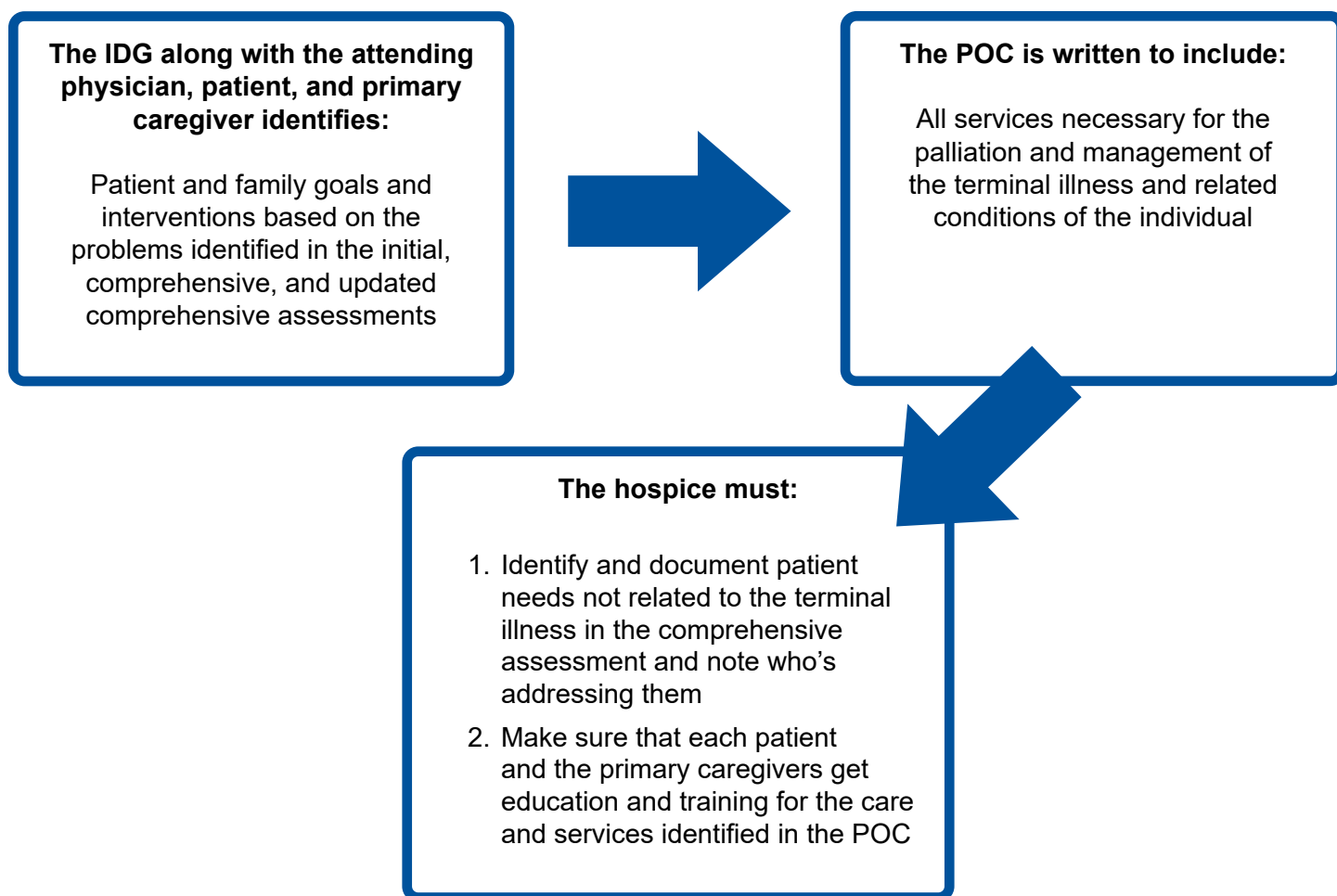
The primary goal of hospice care is to meet the holistic needs of an individual and their caregiver and family when curative care is no longer an option.

To support this goal:

- The hospice provider develops an individualized POC
- An Interdisciplinary Group (IDG) sets up the POC and it's overseen by a Registered Nurse (RN) coordinator

## POC Requirements

All hospice care and services must follow an individualized written POC that meets the patient's and their family's needs.



## Principles of Quality Care Planning

Medicare requires the POC include:

- 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 expected from implementing and coordinating the POC
- Drugs and treatments necessary to meet patient needs
- Medical supplies and appliances necessary to meet patient needs
- IDG documentation of the patient's or representative's level of understanding, involvement, and agreement with the POC

## Care Coordination

The IDG works together to give comfort and dignity to the patient's and family's needs and goals of care. The IDG must include the professions of:

- Nursing
- Medicine
- Social work
- Pastoral or other spiritual counselors

Additional team members may include:

- Representatives from therapeutic services (for example, physical therapy, music and art therapy)
- Other care and supportive personnel like hospice aides and volunteers
- The patient's primary caregiver

The IDG Team:

- Supports and manages the physical, medical, psychosocial, emotional, and spiritual needs of hospice patients and families
- Sets up the POC at the time an individual chooses hospice
- Continuously updates the POC while the patient gets the hospice benefit
- Offers a bereavement POC and supportive services to the caregiver and family for 1 year after the death of the hospice patient

"...The IDG team work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement..."

[42 CFR 418.56 \(a\)](#)

## Common Deficiencies Related to POC Implementation

An OIG [report](#) identified hospice survey deficiencies at the Condition of Participation (CoP) for Interdisciplinary Group, care planning, and coordination of services ([42 CFR 418.56](#)). Common survey deficiencies were related to POC implementation.

For example, the report found that:

- POCs weren't individualized
- Hospice staff missed direct-care visits
- Documentation of visits didn't meet requirements (for example, wound care)
- POCs were incomplete (for example, not inclusive of all needed services)
- IDG meetings were inconsistent, with POCs not being updated

## RN Coordinator

The hospice agency designates an RN. The RN is:

- Identified as the RN Coordinator
- A member of the IDG
- Responsible for coordinating the implementation of the POC
- Responsible for offering direct nursing care to the patient and easing collaboration within the IDG for service delivery

We recognize this role as vital to make sure quality care is properly coordinated and delivered in a timely and meaningful manner.

“...The unique skills of registered nurses, who are educated to assess and manage the overall aspects of a patient's physical and psychosocial care, can be used to oversee the coordination and implementation of the care identified by the IDG...” [Hospice Preamble of Final Rule](#)

The RN Coordinator makes sure the POC is updated, individualized, and relevant to the needs of the patient and family by:

- Continuously assessing each patient's and family's needs
- Documenting and revising patient care goals and objectives in a timely manner under IDG direction
- Communicating with the IDG any changes in the delivery of services from the established POC
- Easing exchange of information among IDG staff, patient, and caregiver
- Working with other members of the IDG to include additional services when needed
- Developing and revising patient care goals and objectives together with other members of the IDG
- Monitoring for successful implementation of the POC

## Resources

---

- [Hospice Coverage](#)
- [Hospice Final Rule](#)
- [OIG Report – Hospice Deficiencies Pose Risks to Medicare Beneficiaries](#)
- [Quality, Certification and Oversight Reports Database](#)
- [Quality, Safety & Education Portal](#)
- [State Operations Manual Appendix M – Guidance to Surveyors: Hospice](#)

View the [Medicare Learning Network® Content Disclaimer and Department of Health & Human Services Disclosure](#).

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).