Creating An Effective Hospice Plan of Care

What's Changed?

- No substantive content updates.

Introduction

The hospice Plan of Care (POC) maps out needs and services supplied for a Medicare patient facing a terminal illness, as well as the patient's family/caregiver. CMS data indicates that some hospice POCs are incomplete or not followed correctly. This fact sheet offers guidance on creating and coordinating successful hospice POCs.

The content in this Medicare Learning Network® educational product doesn't reflect waivers and flexibilities issued pursuant to section 1135 of the Act or short-term regulatory changes made in response to COVID-19. CMS has issued blanket waivers and flexibilities and made temporary changes to its rules to prevent gaps in access to care for patients affected by the COVID-19 public health emergency. Visit MLN Matters® Article SE20011 for up-to-date information and a complete list of COVID-19 blanket waivers and flexibilities, and temporary regulatory changes.

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Hospice Background

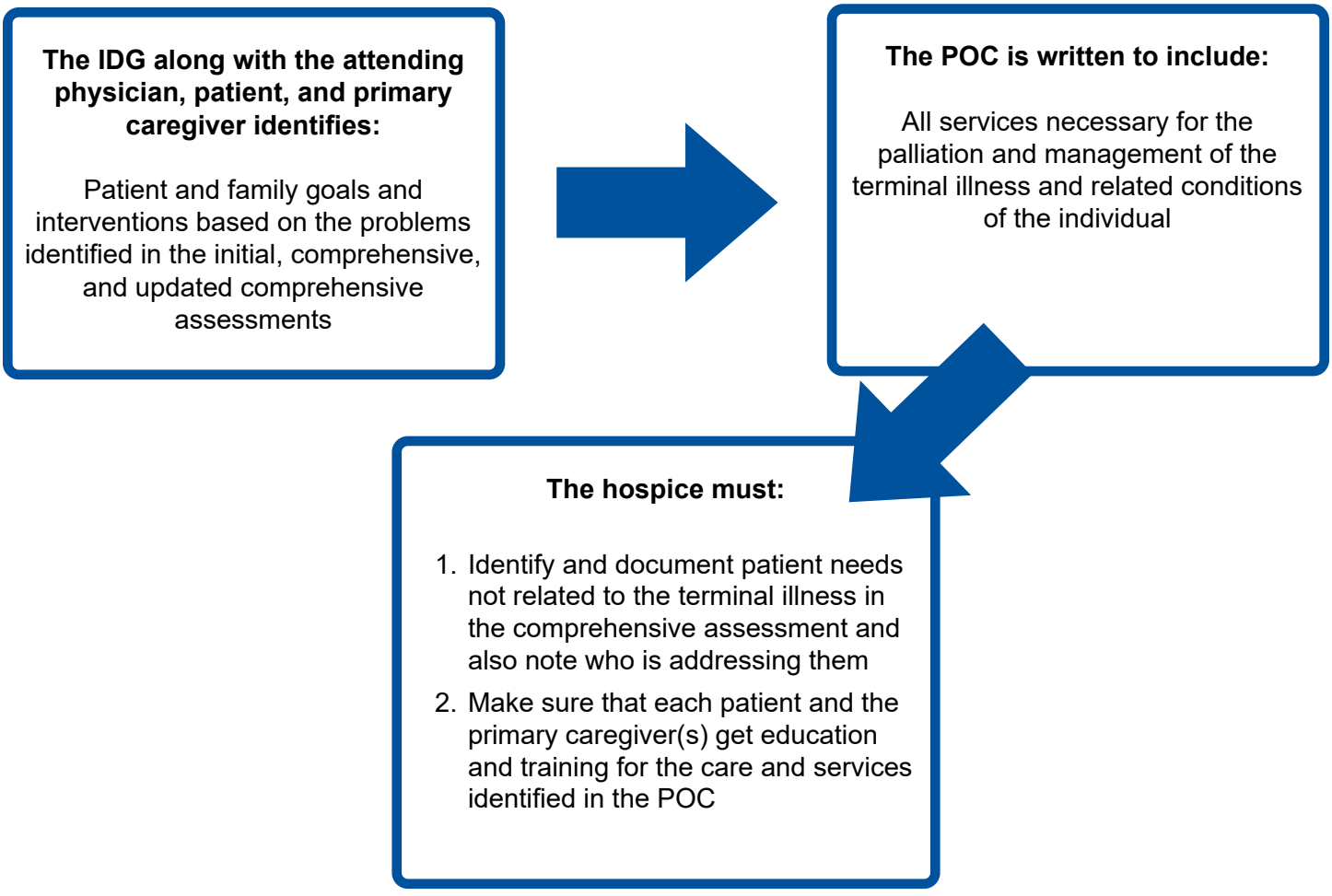
The primary goal of hospice care is to meet the holistic needs of an individual and their caregiver and family when curative care is no longer the preferred option.

To support this goal:

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

POC Requirements

All hospice care and services offered to patients and their families must follow an individualized written POC that meets the patient'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 anticipated 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 provide 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 and music and art therapy)
- Other care and supportive personnel such as 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
- Establishes the POC at the time an individual chooses hospice
- Continuously updates the POC while the patient gets the hospice benefit
- Also, offer a bereavement POC and supportive services to the caregiver and family for one 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) Standard: Approach to service delivery

Common Deficiencies Related to POC Implementation

CMS analyzed 2019 hospice survey deficiency data 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, CMS 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
- Serves as a member of the IDG
- Is responsible for coordinating the implementation of the POC
- Is also responsible for offering direct nursing care to the patient and easing collaboration within the IDG for service delivery

CMS recognizes 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 and patient and caregiver
- Working with other members of the IDG to include additional services when indicated
- Developing and revising patient care goals and objectives in coordination with other members of the IDG
- Monitoring for successful implementation of the POC

Resources

- Hospice Final Rule
- OIG Report (OEI-02-17-00020) Hospice Deficiencies Pose Risks to Medicare Beneficiaries (July 2019)
- Quality, Certification and Oversight Reports (QCOR) Database
- Quality, Safety & Education Portal (QSEP) for Basic Surveyor On-Demand Trainings
- State Operations Manual Appendix M – Guidance to Surveyors - Hospice