

# CREATING AN EFFECTIVE HOSPICE PLAN OF CARE



The Hyperlink Table, at the end of this document, gives the complete URL for each hyperlink.

## 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. The Centers for Medicare & Medicaid Services (CMS) data indicates that some hospice POCs are incomplete or incorrectly enacted. This fact sheet offers guidance on creating and coordinating successful hospice POCs.

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## HOSPICE BACKGROUND

The primary goal of hospice care is to meet the holistic needs of an individual and his/her caregiver/family for whom curative care is no longer the preferred option. To support this goal, the hospice provider develops an individualized plan of care (POC), established by an Interdisciplinary Group (IDG) and overseen by a Registered Nurse (RN) coordinator.

## PLAN OF CARE (POC)

All hospice care and services offered to hospice patients and their families must follow an individualized written POC. The hospice IDG creates the POC in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs.

The POC should reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The POC must include all services necessary for the palliation and management of the terminal illness and related conditions of the individual. The hospice POC should link with the needs identified in the initial/comprehensive assessment.

Hospices may identify needs in the comprehensive assessment that are not related to the terminal illness and related conditions. The assessment should document that the hospice is aware of these needs and if warranted, note who is addressing them. The hospice must ensure that each patient and the primary caregiver(s) get education and training as appropriate to their responsibilities for the care and services identified in the plan of care.

## **PRINCIPLES OF CARE PLANNING TO PROMOTE QUALITY OF CARE**

Medicare requires the POC include the following elements:

1. Interventions to manage pain and symptoms
2. A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs
3. Measurable outcomes anticipated from implementing and coordinating the POC
4. Drugs and treatments necessary to meet the needs of the patient
5. Medical supplies and appliances necessary to meet the needs of the patient
6. The IDG documentation of the patient's or representative's level of understanding, involvement, and agreement with the POC, in accordance with the hospice's own policies, in the clinical record

## **CARE COORDINATION**

The IDG works as a coordinated team to optimize comfort and dignity according to the patient's and family's needs and goals of care. The IDG must include (at a minimum) the professions of nursing, medicine, social work, and pastoral or other spiritual counselors. Additional team members may include representatives from other therapeutic services (for example, physical therapy and music and art therapy), as well as other care and supportive personnel such as hospice aides and volunteers. Additionally, hospices are encouraged to include the patient's primary caregiver as a participant in the IDG.

The IDG is positioned to support and manage the physical, medical, psychosocial, emotional, and spiritual needs of hospice patients and families through an individualized POC. The IDG establishes the POC at the time an individual elects hospice, and continuously updates the POC while the patient gets the hospice benefit. Additionally, the hospice must offer a bereavement POC and supportive services to the caregiver/family for one year after the death of the hospice patient to further support the bereaved family.

"...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

The Centers for Medicare & Medicaid Services (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 were not individualized
- Hospice staff missed direct-care visits
- Documentation of visits did not 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

CMS requires that the hospice agency designate an RN, who may be identified as the RN Coordinator, who serves as a member of the IDG and is responsible for coordinating the implementation of the POC. This person may also be 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 ensuring that quality care is appropriately 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 ensures the POC remains updated, individualized, and relevant to the needs of the patient and family by:

- Ensuring the continuous assessment of each patient’s and family’s needs
- Documenting and revising patient care goals/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/caregiver
- Working with other members of the IDG to ease inclusion of additional services when indicated
- Developing and revising patient care goals/objectives in coordination with other members of the IDG
- Monitoring for successful implementation of the POC

Implementation is the beginning of ongoing management for compliance with hospice COPs in addition to patient and family goals.

## KEY TAKEAWAYS

- All hospice care and services offered to hospice patients and their families must follow an individualized written POC.
- The POC should reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments.
- The RN Coordinator can ensure the POC remains updated, individualized, and relevant to the needs of the patient and family.
- POCs must document any deviations to the services offered. Hospices must update POCs based on the needs of the individual or those the IDG identifies.

## RESOURCES

**Table 1. Hospice Resources**

Resource	Website
Hospice Final Rule	<a href="https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Hospice">https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Hospice</a>
MLN Matters® Article SE20011	<a href="https://www.cms.gov/files/document/se20011.pdf">https://www.cms.gov/files/document/se20011.pdf</a>
OIG Report (OEI-02-17-00020) Hospice Deficiencies Pose Risks to Medicare Beneficiaries (July 2019)	<a href="https://oig.hhs.gov/oei/reports/oei-02-17-00020.asp">https://oig.hhs.gov/oei/reports/oei-02-17-00020.asp</a>
Quality, Certification and Oversight Reports (QCOR) database: Contains various survey reports and data reporting elements for surveys conducted by State Agency (SA); includes complaint survey information from both hospice Accrediting Organizations (AO) and State Survey Agencies (SA). To enhance transparency, CMS has made this portal public facing.	<a href="https://qcor.cms.gov/main.jsp">https://qcor.cms.gov/main.jsp</a>
Quality, Safety & Education Portal (QSEP) for certified provider/supplier basic surveyor on-demand trainings	<a href="https://qsep.cms.gov/welcome.aspx">https://qsep.cms.gov/welcome.aspx</a>
State Operations Manual Appendix M – Guidance to Surveyors - Hospice	<a href="https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf">https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf</a>

## HYPERLINKS

**Table 2. Hyperlink Table**

Embedded Hyperlink	Complete URL
MLN Matters® Article SE20011	<a href="https://www.cms.gov/files/document/se20011.pdf">https://www.cms.gov/files/document/se20011.pdf</a>

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