Hospice 101 Class 2

Home Health Foundation
The Leaders in Home Health and Hospice Care

Circle Home | Commonwealth Nursing Services | Hallmark Health VNA | Home Health VNA | Home Health VNA of NH | Merrimack Valley Hospice | York Hospital Hospice

Hospice 101 – Class 2

- Hospice Initial & Comprehensive Assessment
- Hospice Discharge, Revocation & Transfers
- NONC and ABN
- Hospice Documentation
- Hospice Recertification
- Interdisciplinary Team Meetings (IDT)
- QAPI and Hospice Item Set (HIS)
- Hospice Benefit Periods & Hospice FTF
- Hospice CAHPS Survey
- Death in the Home RN Pronouncement

Hospice Admission Required Elements

- Physicians orders to admit hospice services
- Admission packet
- Referral information
- History and Physical info
- Electronic Medical Record (EMR)

Hospice Admission Forms

- Notice of Election
- MA Election for Mass Health/Medicaid insured
- Verification of Reimbursement (VOR) for SNF only

Prior to Hospice Admission

- Confirm there is a physician order for admission to hospice services
- Call the patient/caregiver to schedule the admission visit, requesting all third party payer information & medications are available for you to review
- Review the history and physical from the referral source
- Gather info to support hospice criteria for terminal diagnosis

Hospice Admission Items to Review- Admission packet

- Information about the agency
- How to reach the agency
- How to call the state hotline
- Agency's admission & discharge policies
- Patients rights & responsibilities
- Safety information
- Emergency information

Discussions for all admissions must include

- Explanation of benefits including medication coverage criteria
- Role of all disciplines
- Patient history
- Goals of patient/family
- Explain medications for comfort

Initial and Comprehensive Assessment

- Completed by hospice RN within 48 hours of election
- Is an overall assessment of the patient/family immediate needs
- The hospice interdisciplinary team must complete the comprehensive assessment within 5 days of the election
- Must identify the physical, psychosocial emotional & spiritual needs related to the terminal illness that must be addressed in order to promote the patient's comfort & dignity throughout the dying process

Assessment Must Take into Consideration the following

- Condition causing admission
- Co-morbidities
- Complications and risk factors
- Functional status
- Severity of symptoms
- Imminence of death

Drug Medication Profile

- Medication reconciliation
- All prescription, OTC & Herbal remedies
- Identification of
  - Effectiveness
  - Side effects
  - Actual/potential drug interactions
  - Duplicate drug therapy
  - Lab monitoring

Hospice Admission Procedure

- Ascertain the patient/caregiver goals & wishes for end of life
- Discuss/obtain copy of Advance Directives
- Clarify services hospice will provide
- Clarify goals of care

Hospice Admission Procedure

- Complete
  - Integrated Assessment
  - Hospice Item Set
  - Narrative Note
- Obtain signature on NOE and any other forms required

Hospice Admission Procedure

- Ask about caregiver's status
- Discuss initial plan of care with patient/family
- Who else will visit from hospice
- Anticipated visit schedule
- How to reach the agency & importance of calling for all medical needs
- Teach do not call 911 or go to the hospital without calling hospice first or you may be financially responsible

Topics That Will be Discussed with the Physician

- Hospice admission procedure
- Complete plan of care orders
- Assure complete documentation of the assessment and plan of care

Hospice Admission Calls to Make

- Primary MD
- Confirm terminal prognosis of less than six months
- Obtain order for medications
- Call Long Term Pharmacy to order Comfort Kit
- Call Home Care Specialists for equipment

SNF Admission

- Check/obtain order for hospice
- Communicate with social worker to inform of hospice admission
- Communicate face to face with staff re: recommendations
- Make copies of
  - DNR/MOLST
  - HealthCare Proxy
  - Invocation of Proxy if one exists
  - Med list

SNF Admission

- Obtain Verification of Reimbursement (VOR) for SNF only
- Complete admission and print the following to leave in chart at SNF
  - Med list
  - Nursing assessment
  - Yellow copy of Consent Form
  - Use green tab in front of printed forms in the SNF chart and put info sheet for hospice in front of the chart
- HCA frequency in SNF if determined by individual plan of care

Hospice Discharge, Revocation and Transfers

- Hospice may discharge a beneficiary in certain circumstances
- Only a beneficiary or a representative my revoke the election of the hospice benefit. Hospice cannot revoke.
- A beneficiary may transfer hospice agencies only once in each benefit period

Discharge from Hospice

- Hospice cannot revoke the beneficiary's election of the hospice benefit
- Hospice may not discharge the beneficiary at its discretion even if the care promises to be costly or inconvenient
- Hospice may bill for the day of discharge

Reasons for Discharge from Hospice

- Beneficiary moves of the hospice service area
- Beneficiary goes into a non-contracted facility
- Beneficiary transfers to another hospice
- Hospice determines the beneficiary is no longer terminally ill
- Discharge for cause

Discharge from Hospice

- Must be given Notice of Non-coverage at least 48 hours before discharge
- The patient has the right to appeal
- Discharge order from the Medical Director
- Consultation with attending physician
- Discharge summary sent to attending physician
- The beneficiary may at any time elect the hospice benefit if they are again eligible & would be admitted into the next benefit period

Revocation of the Election

- Revocation is a beneficiary's choice to no longer receive Medicare covered hospice benefits
- Patient may revoke at any time
- A verbal revocation of benefits is NOT acceptable
- Beneficiary/representative must sign a written statement of revocation
- The day of revocation is a billable day

Transfer

- Transfer is a change of the designated hospice
- May occur once in a benefit period
- Patient must sign a statement with the names of both hospices and the date of the transfer
- The date of the transfer is billable by both hospice agencies

Transfer

- A second transfer in a benefit period requires a discharge and re-admission into the next benefit period

Advance Beneficiary Notice (ABN)

- The ABN is only required when the beneficiary expects to receive services that the hospice Medicare benefit will not cover
- Example – High Pointe House patient wants to stay on GIP, but GIP eligibility is not met

Advance Beneficiary Notice is not Required for

- Live discharge
- Revocation
- Respite care beyond 5 days
- Transfers
- Emergent care not arranged/coordinated by hospice

Advance Beneficiary Notice (ABN)

- If you do not issue a valid ABN to the beneficiary when required by Medicare, the agency cannot bill the beneficiary for the service and the agency may be finally liable

Notice of Non-Coverage (NONC)

- When a patient is being discharged by hospice for no longer meeting Medicare eligibility for hospice, the patient/family has the right to appeal the decision
- Must give the patient the NONC form no later than 2 days before the effective date of discharge
- Informs patient of the right to appeal & request an expedited review

Hospice Documentation

- Hospice documentation should provide an accurate visual presentation of patient status supporting the terminal prognosis
- Clinician's documentation needs to substantiate the terminal prognosis with sufficient clinical information to support the patient's initial certification and any subsequent re-certifications

Hospice Documentation

- Include documentation that reflects the patient's physical decline or structural/functional impairments over the period of care
- When documenting assessments and care, keep in mind the principles of good documentation:
  - Accurate
  - Concise
  - Comprehensive
  - Patient centered

Hospice Clinical Record

- Each patient's record must include the following:
  - The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.
  - Signed copies of the notice of patient rights and election statement
  - Responses to medications, symptom management, treatments, and services.

Hospice Clinical Record

- Each patient's record must include the following:
  - Outcome measure data elements
  - Physician certification and recertification of terminal illness
  - Any advance directives as described in Physician orders.

Documentation of Possible Quantifiable Values/Measures

- Change in patient's weight (pounds, kilograms)
- Worsening diagnostic lab results (increase, decrease)
- Change in pain
  - Type (ache, throb, sharp)
  - Intensity (Level 0-10)
  - Location (upper, lower)
  - Frequency (hourly, daily)
  - Medication usage (dosage, frequency)

Documentation of Possible Quantifiable Values/Measures

- Change in responsiveness (fading, alert, unresponsive)
- Skin thickness/condition (fragile, intact, tears easily)
- Dependence on ADLs
  - Occurrences of incontinence
  - Dress (assisted, unassisted)
  - Bathe (assisted, unassisted)
  - Ambulation ability (assisted, unassisted)
  - Ambulation distance (feet, steps)

Documentation of Possible Quantifiable Values/Measures

- Upper arm measurements
- Abdominal girth (inches, centimeters)
- Change in signs
  - Respiratory rate (increased, decreased)
  - Oxygen flow rate (liters)
  - Hyper/hypotension
  - Radial/apical pulse (tachycardic, bradycardic, regular, irregular)
  - O2 Sats

Documentation of Possible Quantifiable Values/Measures

- Edema (level 1-4, pitting, non-pitting)
- Turgor (slow, normal)
- Change in strength/weakness (level 0-5)
- Change in lucidity (oriented, confused)

Documentation of Possible Quantifiable Values/Measures

- Measurement/change in intake/output
  - Amount (cups, liters, ounces, teaspoons, mgs, ml, cc)
  - Percentage of meals eaten
  - Frequency
- PPS decreasing
- FAST (Functional Assessment Scale)

Prior to Claim Submission Ensure the Following

- Notice of Election (NOE) was signed and dated at start of care
- Certification/recertification (CTI) was signed and dated according to Medicare regulations
- Plan of Treatment (POT) signed and dated according to Medicare regulations
- The number of days/time and visits for each level of care is identified

Plan of Care

- The plan of care is written and:
- Reflect patient and family goals
- Include collaboration of the attending physician
- Includes interventions for problems identified at assessment
- Include all disciplines (frequency and duration) necessary for management of terminal illness

Review of the POC

- POC must be reviewed and updated by the IDT at least every 15 calendar days
- The POC should be updated if the patient's condition improves or deteriorates, or when the level of care changes
- Continually reviewed to ensure care received meets current conditions and needs.

Certification/Recertification

- Certification and recertification must be based on the physician's clinical judgment
- Supporting clinical documentation must be present in the medical record
- The physician must include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less and the physician must attest that he/she composed the narrative .
- Certification of Terminal Illness (CTI)

Certification/Recertification

- If written certification cannot be obtained within 2 calendar days than an oral (verbal) certification must be obtained
- Written certification must be on file before submitting the claim
- Recertification may not be completed more than 15 days prior to start of next benefit period

Certification/Recertification

- For the initial benefit period, the certification of the terminal illness (oral and written) must be obtained from the medical director and the attending (if any)
- For subsequent periods – recertification by only one of the physicians is required (this is usually the Medical Director)

Hospice Recertification

- All Hospice patients will be evaluated by the Interdisciplinary Team (IDT) for continued Hospice appropriateness prior to the recertification date
- The RN case manager makes a recert visit to the patient
- See fact sheet

Hospice Recertification

- The RN case manager nurse facilitates a thorough discussion of the patient's current status and eligibility for recertification for Hospice with input from members of IDT and Medical Director
- This discussion, including findings, is thoroughly documented in the clinical record

Interdisciplinary Team (IDT)

- The Interdisciplinary team (IDT) works together to meet the physical, medical, psychosocial, emotional, spiritual and bereavement needs
- A designated RN provides coordination of care, and ensures continuous assessment of needs, and implementation of the plan of care
- The IDT includes a doctor, an RN, a social worker and a pastoral counselor

Interdisciplinary Team (IDT)

- Patient is assessed by each discipline. Problems, goals& interventions are identified based on patient/family needs & goals and this becomes the POC
- Each discipline provides care and services to patient; each visit and visit note should be focused on a problem identified in the POC and reflect professional interventions to achieve the identified goal

Interdisciplinary Team (IDT)

- Increases or decreases in frequency of visits by team members, and reason for the change
- Changes in the location of care
- Psychosocial and other consultations/conferences with patient/family/caregiver
- Ongoing spiritual needs

Interdisciplinary Team (IDT)

- Plan for future interventions
- Progress/lack of progress toward treatment goals for each problem addressed
- Review new admissions
- Review re-certification and eligibility
- Begin bereavement care planning

Interdisciplinary Team Process

- Each patient's plan of care is reviewed every 15 days and more often if necessary, by the patient's status and level of care
- The meeting is facilitated by the Clinical Manager/designee
- Volunteers are invited to attend if available
- IDT meeting is held weekly

Interdisciplinary Team Process

- IDT members sign into the meeting electronically via the clinical record
- Prior to the meeting, each team member develops an IDT update in the clinical record, which includes but not limited to
- Medication and their effectiveness; medication changes

Interdisciplinary Team Process

- An increase or decrease in symptoms or acuity, including nutritional status, pain management, and condition of skin including the presence/status of pressure ulcers
- Problem solving for optimal care of the patient/family/caregiver occurs and changes are documented on the IDT Care Plan Review

Interdisciplinary Team Process

- For patients residing in a SNF, any changes in the POC will be communicated to the nursing staff of the SNF
- Verbal orders are obtained from the Attending Physician as required for any changes to the POC

Interdisciplinary Team Process

- IDT members present information at the meeting related to the patient/family/caregiver that may include but is not limited to:
  - Patient's name, diagnosis and date of admission
  - Patient's location, and availability of family and caregiver(s)
  - Identified problems and goals
  - Outcome of interventions and status of problems (i.e. unchanged, resolved)

Interdisciplinary Team Process

- Pertinent information related to the patient's current status and changes since the previous team discussion
- Scope and frequency of services provided
- Continued eligibility for Hospice services

Quality Assessment Performance Improvement (QAPI)

- **Program must be:**
  - Effective, ongoing, data driven
  - Involving of all hospice services
  - Focused on improved outcomes for patients and families
  - Focused on improvements in hospice performance

Quality Assessment Performance Improvement (QAPI)

- **Quality Indicators**
  - Patient care related - HIS
  - Safety related – Incidents & Infections
  - Satisfaction related - CAHPS and Complaints
  - Chart review /documentation indicators

Hospice Item Set (HIS)

HIS Measures	Explanation
Treatment Preferences	CPR Preference Other Life-sustaining Treatment Preferences Hospitalization Preference
Belief Value	Spiritual/Existential Concerns
Pain Screening	Was the patient screened for pain? The patient's pain severity Type of standardized pain tool used
Pain Assessment	Was a comprehensive pain assessment done? Comprehensive pain assessment includes at least 5 of 7 pain assessment elements (location, severity, character, duration, frequency, what relieves/worsens pain, effect on function or quality of life)
Dyspnea Screen	Was the patient screened for shortness of breath?
Dyspnea Treatment	Was the treatment for shortness of breath initiated? Types of treatment (just check at least one treatment – opioids, other medication, oxygen or non-medication)
Opioid Bowel Regimen	Was a scheduled opioid initiated or continued? If answer to above no, then was a PRN opioid initiated or continued? Was a bowel regimen initiated or continued?

Hospice Item Set (HIS) Pain Assessment

One of the 7 HIS measures is “Pain Assessment.”

The pain assessment must include at least 5 of the 7 pain assessment elements.

The 7 pain assessment elements are:

1. Location
2. Severity
3. Character
4. Duration
5. Frequency
6. What relieves/worsens pain
7. Effect on function or quality of life

Hospice Benefit Periods

- The Medicare Hospice benefit consists of 90-day benefit periods and an unlimited number of 60-day benefit periods
- The benefit periods must be used in that order (90-90-60)
- The two 90-day benefit periods are not renewable – once they are used, the beneficiary has only 60-day benefit periods remaining

Hospice Benefit Periods

- Ask on admission “Have you ever been on Hospice before?”
- If/when the beneficiary meets the Hospice coverage requirements, they can re-elect the Hospice benefit, and will begin with the next benefit period

Hospice Face-to-Face (FTF)

- For patients with Medicare coverage, who are entering the third or later certification period, a face to face visit by the Medical Director or Nurse Practitioner or Hospice Physician is required to determine continued eligibility for Hospice care
- The FTF encounter must document the clinical findings supporting a life expectancy of 6 months or less

Hospice Face-to-Face

- When the FTF requirements are not met, the patient is no longer eligible for the Medicare Hospice benefit
- The FTF encounter must occur within 30 calendar days prior to the start of the third benefit period and each subsequent recertification
- If the patient dies within 2 days of admission, a FTF encounter is considered to be complete

Hospice Face-to-Face

- The FTF encounter must be performed by a Hospice physician or a Hospice Nurse Practitioner employed or under contract by the Hospice
- The Hospice physician or Nurse Practitioner must attest in writing that he or she had a Face-to-Face encounter with the patient, including the date of the encounter

Hospice Face-to-Face

- The attestation, which must be a separate and distinct part of the recertification, or as an addendum to the recertification associated with the third benefit period
- Clearly titled
- Accompanying signature, and date signed by the individual who performed the visit

Hospice Face-to-Face

- Date of the visit
- Clinical findings to determine continued Hospice eligibility
- The clinical findings must be reported to the certifying physician

Hospice CAHPS Survey

- National survey for CMS (Center for Medicaid and Medicare Services)
- Developed using the same process as other CAHPS surveys – current use for Home Health Care
- Selected measures from the survey will be used as national quality measures

Hospice CAHPS Survey

- Includes 47 Core questions
- Focus on patient/caregiver experience of care rather than caregiver satisfaction
- Covered topics include:
- Hospice Team Communication
- Getting timely care

Hospice CAHPS Survey

- Treating family members with respect
- Providing emotional support
- Support for Religious and Spiritual Beliefs
- Getting help for symptoms

Hospice CAHPS Survey

- Information continuity
- Understanding the side effects of medication
- Focus is on experiences and behaviors

Hospice CAHPS Survey

- Hospices are required to send surveys (through a designated vendor)
- Surveys will be sent on a monthly basis
- Post death survey is sent to the primary caregiver

Hospice CAHPS Survey

- To allow the caregiver some recovery time, the survey will be mailed two months after the month of death
- If the survey is not received in 21 days a second survey and reminder letter is mailed

Death in the Home RN Pronouncement

- Registered nurses employed by MVH/YHH may make the pronouncement of death, in accordance with applicable state laws
- All deaths of MVH/YHH patients in the home require a visit by a RN to complete the pronouncement of death for patients in Massachusetts and New Hampshire, and the determination of lack of vital signs in Maine

Death in the Home RN Pronouncement

- For patients in Massachusetts and New Hampshire, the time of pronouncement is the official time of death
- IDT staff will provide support and comfort to the family/caregivers
- MVH/YHH clinical staff will discuss with the patient/family, the anticipated death and funeral plans

Death in the Home RN Pronouncement

- MVH/YHH staff will encourage the patient/family to make arrangements in advance, to ensure that the patient's wishes are acknowledged and respected, as well as to prevent the need for decision-making at the time of death
- Families/caregivers are instructed to call MVH/YHHPC at the time of death

Death in the Home RN Pronouncement

- When MVH/YHH is notified that the patient has died, a RN will make a home visit
- The RN will confirm the death by assessing the patient's vital signs

Death in the Home RN Pronouncement

- The RN will obtain information from the family/caregiver regarding the circumstances of the patient's death
- After the patient's death has been confirmed, the physician or medical examiner is notified

Death in the Home RN Pronouncement

- In Massachusetts, the medical examiner must be notified in the case of the death of a child under 18 years of age
- The medical examiner will inquire as to the circumstances of the death and decide whether to take jurisdiction
- If the medical examiner does not take jurisdiction, the deceased may be released to the funeral home

Death in the Home RN Pronouncement

- If the medical examiner takes jurisdiction, the medical examiner will take possession of the deceased
- In Massachusetts and New Hampshire, the RN will make the formal pronouncement of death, completing all required documentation

Death in the Home RN Pronouncement

- For Massachusetts patients, the form for pronouncement of death is the Pronouncement of Death Form by the Registry of Vital Records and Statistics in the Commonwealth of Massachusetts

Pronouncement of Death

- It is completed according to the instructions on the reverse side of the form
- For New Hampshire patients the form completed for the pronouncement of death is the Certificate of Death
- Only Sections 22-26B and item 32 are completed according to the instructions on the back of the form

Pronouncement of Death

- The deceased cannot be transported across county lines without a completed death certificate
- The death certificate must be completed by the medical examiner or attending physician
- The Pronouncement of Death note will be completed in the clinical record

Pronouncement of Death

- In Maine, the nurse will notify the attending physician of the absence of vital signs and will document this in the vital signs section of the nurse visit note
- The time of communication of this information to the attending physician will be noted in the communication section of the nurse visit note

Pronouncement of Death

- The RN ensures that the funeral home has been called
- The appropriate completed pronouncement form will be prepared and left for the funeral home licensee in accordance with Massachusetts and New Hampshire laws

Pronouncement of Death

- In Maine, the nurse will inform the funeral home licensee that the attending physician has been notified
- Support is provided to the family/caregiver as indicated

Death of a Suspicious Nature

- If the circumstances surrounding the death are suspicious or potentially due to another cause (i.e. – a fall), the RN will not pronounce the patient dead
- The RN will immediately notify his/her supervisor or administrator on-call of the event

Death of a Suspicious Nature

- The supervisor/administrator on-call will direct the RN to call 911 to report a suspicious death, and to notify the attending physician of the situation
- An agency incident report will also be completed

Death Pronouncement Checklist

- Required Orders
  - DNR order in place
  - Physician order to pronounce death
- Prepare family
  - Review purpose
  - Review process
  - Who to call
  - Do not call 911

Death Pronouncement Checklist

- Arrival in home and Pronouncement
  - Be reassuring and confident
  - Address the patient, introduce self
  - Listen to heart for one full minute
  - Check pupils for fixing and dilation
  - Observe for respirations

Death Pronouncement Checklist

- Post Mortem Care
  - Inform family of the elements of pm care
  - Ask re: cultural considerations
  - Invite family to participate or observe
  - Place patient in supine position
  - Elevate the head of the bed, to prevent livor mortis which is the pooling of blood appearing as a dark reddish purple color on the face.

Death Pronouncement Checklist

- Post Mortem Care
  - Straighten the limbs
  - Gently hold eyelids closed, until they remain closed. If eyes do not remain closed, moisten gauze pads and place over closed lids until they remain closed without assistance
  - Rigor mortis, the progressive stiffening of muscles can begin as soon as 10 minutes after death, beginning with the face. For this reason place a rolled up washcloth to keep the mouth closed until the jaw stiffens.

Death Pronouncement Checklist

- Post Mortem Care
  - Wash body- While a full bath may not be necessary, remove all visible blood and body fluids.
  - Remove SQ devices, Foley
  - Leave in place PICCs, Ports, Pleurex
  - Replace ostomy appliances with new ones
  - If incontinence; replace depends, use padding
  - Change linens as needed, change pillow case.
  - Change into clean clothing
  - Comb hair

Death Pronouncement Checklist

- Contact physician and completing the paperwork
  - Contact the physician at the time of death – that death has occurred and where body will be taken.
  - Have forms and black pens with you.
  - For Massachusetts pronouncements you must have your RN license number with you. (Take picture of your license and keep in phone, or on a slip of paper with your forms).

Death Pronouncement Checklist

- Contact physician and completing the paperwork
  - Complete forms according to the form directions.
  - Review the directions if you are not familiar with them.
  - Time of death is when you pronounced the death, not the time you were contacted.
  - Leave form for funeral director