The Plan of Care and Comprehensive Assessment

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KNOWLEDGE • EXPERTISE • COMMON SENSE

Objectives

- Understand the elements and rules related to the comprehensive assessment and ongoing assessment of hospice patients
- Understand the risk of poor care planning
- Understand the *process* of interdisciplinary care planning and coordination
- Understand the overarching expectations of quality and compliance as they apply to these team functions

Why are we talking about this?

2018

- **Plan of Care -- L543**
- **Drug Profile—L530**
- **Supervision of Hospice Aides—L629**
- **Timeframe for Completion of Comprehensive Assessment—L523**
- **Content of Plan of Care—L545,L547**
- **Level of Volunteer Activity—L647**
- **Coordination of Services—L555**
- **Infection Prevention—L579**
- **Bereavement—L531**

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…and

- The OIG produced a report in late 2019 regarding the failure of nurses to supervise the care provided by home health aides. This is also a care planning issue.

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What's the Problem?

- Not delivering care according to the plan of care
- Not having orders for items on the plan of care
- Not including the required individuals in development of the plan of care
- Not incorporating updated comprehensive assessment information into the plan of care/not individualizing this information

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The 2019 OIG Report

- The OIG has concluded that the way hospices operate poses a risk to hospice patients, and they want CMS to take steps to protect patients and families from harm
  - Patient assessment does not include key information
  - Not following the Plan of Care
  - Poor coordination of care
  - Not delivering services on the Plan of Care
  - Nor responding appropriately to issues identified on the Plan of Care

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Why don't we get it?

- Grass roots
- History of intuitive practice in hospice
- Low scrutiny
- Absence of intermediary consequences
- Early precedent of diminishing hospice
- Value of "heart" over professionalism
- Format and forms not provided by Medicare

418.54 Comprehensive Assessment

- Include the patient's health status and include information to create and monitor a Plan of Care
- RN is due within 48 hours of election
- Check the date and time of election, and the date and time of the initial assessment
- A plan of care must be established prior to beginning care, so this would be complete before the start of care; the key is to document it.

418.54 Comprehensive Assessment

- Completion no later than 5 calendar days
- All members must participate
- E mail, faxing, texting and phone calls are fine
- Consider the information gathered and decide on a plan, and who should visit

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418.54 Comprehensive Assessment

- Screen for: pain, dyspnea, nausea, vomiting, anxiety, constipation etc. Also emotional distress, spiritual needs, family counseling and education, support/concrete needs
- Consider: why hospice now? Risk factors, imminence of death, symptom severity, bereavement and referrals

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Lay of the Land

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Or.....

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Simple, but not easy:

- Your plan of care is identified in the content of your initial and ongoing assessment

Sample Comprehensive Assessment

- Skin is intact, some redness
- Pain 8/10, unresponsive to meds
- Jehovah's Witness, local Kingdom Hall affiliation
- Adult son is estranged from family
- Patient's husband is older, and has dementia, anxious
- Couple lives alone

418.54 Comprehensive Assessment

- Update:
  - Whenever there are changes, but no less than every 15 days
- "Evaluate and document the patient's response to the care, treatment and services provided, and progress toward desired outcomes"
- Change the Plan of Care accordingly

Outcome Measures

ASSESSMENT	GOALS
• Skin is intact, some redness	• Maintain skin integrity
• Pain 8/10, unresponsive to meds	• Pain below 3 (SIT)
• Jehovah's Witness, local Kingdom Hall affiliation	• Spiritual needs met per patient report and preference
• Adult son is estranged from family	• Son is not to enter the home or contact the patient
• Patient's husband is older, and has dementia, anxious	• Decreased anxiety, able to care for wife
• Couple lives alone	• Remain at home

Plan of Care

- All services necessary for the palliation and management of the terminal illness, and related conditions.
- The Plan of Care must be established *before* services are provided
- Individualized, and composed with feedback from the hospice team, the attending physician, the patient and the primary caregiver
- Provide patient and family with education as appropriate to their responsibilities for the care and services in the Plan of Care.

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Interventions

GOALS

- Maintain skin integrity
- Pain below 3 (SIT)
- Spiritual needs met per patient report and preference
- Son is not to enter the home or contact the patient
- Decreased anxiety, able to care for wife
- Remain at home

INTERVENTIONS

- Turn patient, skin regimen
- Consult palliative specialist
- No new goal
- Communicate with hospice staff and with son, support for son
- Consult with husband's PCP, support and education for husband
- HHA, social support, hired care

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Scope and Frequency

INTERVENTIONS	WHO and WHEN
• Turn patient, skin regimen	• RN and HHA, 2x and 3x weekly total
• Consult palliative specialist	• No intervention/no visit
• No new goal	• Hospice doc, RN, 2x weekly
• Communicate with hospice staff and with son, support for son	• Social worker, weekly
• Consult with husband's PCP, support and education for husband	• RN and HHA, see above
• HHA, social support, hired care	• HHA, SW

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Data Elements

GOALS	Metric
• Maintain skin integrity	• RN observation, wound staging
• Pain below 3 (SIT)	• Wong-Baker Scale
• Spiritual needs met per patient report and preference	• Patent report and preference
• Son is not to enter the home or contact the patient	• Patient and social worker report
• Decreased anxiety, able to care for wife	• Hamilton Anxiety scale
• Remain at home	• Family report

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Measuring Outcomes

- The scales should be present at admission and carried through
- Everyone has to use the same scales, and be trained to use them
- Aggregation for QAPI is important for program evaluation

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Updated Assessment

ASSESSMENT	UPDATE
• Skin is intact, some redness	• Stage 1 wound
• Pain 8/10, unresponsive to meds	• Pain 2/10
• Jehovah's Witness, local Kingdom Hall affiliation	• No change
• Adult son is estranged from family	• Mother is asking to see her son now
• Patient's husband is older, and has dementia, anxious	• Relief with Ativan and family support, rating 24 down from 42
• Couple lives alone	• Maintained safely at home

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Speaking of Scales

- HOPE is on the way!
  - Assessment of key metrics at key intervals
  - Everyone will be collecting the same things in the same way
  - Will replace the Hospice Item Set
  - Public reporting on outcomes
  - Draft version yo be piloted in 2020
  - HOPE measures become the Plan of Care

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418.56 IDG Planning & Coordination of Services

- Designate an Interdisciplinary Group
  - Doctor (DO or MD)
  - Registered Nurse
  - Social Worker
  - Pastoral or other Counselor
- RN provides coordination of care and ensures continuous assessment

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418.56 IDG Planning & Coordination of Services

- Content
  - Interventions addressing pain, symptoms and other problems identified in the assessment
  - Detailed statement of the scope and frequency of services
  - Drugs and treatments necessary
  - Medical supplies and appliances
  - Documentation of the patient/family understanding, involvement and agreement with the Plan of Care
  - Reflects patient/family goals
  - Measurable targeted outcomes

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Coordination and Communication

- Avoiding burdensome transitions
- Billing outside the hospice benefit
- Virtually all care is related
- Multidisciplinary vs Interdisciplinary care
- Communication with outside/other providers

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Problem Areas

- Staff not trained to provide the care called for
- Needs identified and not addressed or measured
- Changes to condition with no change to the plan of care
- “Cookie-cutter” plans
- Wide ranges for visit frequencies

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Ranges for Visits

- Ranges and PRN are permitted
- “O” as a frequency is not OK; 0-3 visits a week
- Small ranges are ok, 1-3, 3-5
- Extra visits are OK if the reason is documented
- High use of PRN visits may indicate a need for change to frequency

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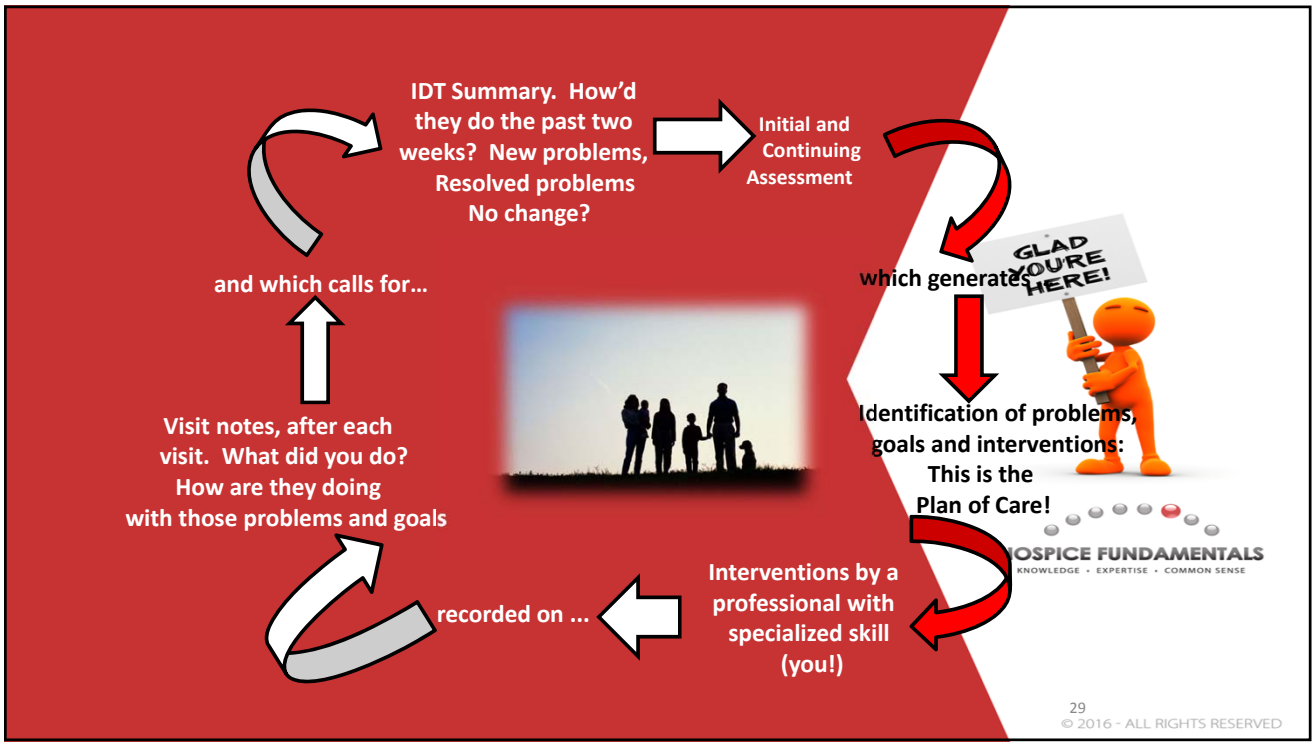

New Family: Initial Comprehensive Assessment

RN: Patient rates pain as 2/10 with 4 as acceptable level, comfort maintained with Hydrocodone XXX. Weight: 98#. Complains of constipation, has not had bowel movement in three days, her usual frequency was daily. Redness on buttocks from sitting up in bed all day reading. Does not move due to dyspnea upon exertion, unable to walk any distance without disabling SOB.

Problems?

- Pain
  - Interventions and goals?
- Alteration in Bowel Function
  - Interventions and goals?
- Skin Integrity
  - Intervention and goals?
- Dyspnea
  - Interventions and goals?

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Initial Comprehensive Assessment

SW: Met with patient and her husband. Son, who is a nurse, has moved in with the family to assist with care. Son was drinking a beer although it was 9:00 a.m. Social network from 55+ community and faith community provide support and some daytime respite care. Son has concerns that healthcare proxy is father, who has early dementia and cannot read. Final arrangements in place since 1970s at family plot.

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Problems?

- Difficulty coping?
- Addiction?
- Advance directives?
  - Goals and Interventions?

Initial Comprehensive Assessment

Chaplain: Phoned family, who declined a chaplain visit at this time. They are Atheist with a supportive and involved community at the local Unitarian Universalist fellowship

Problems?

Spiritual Issues?

One Month Later

RN: Patient is having trouble swallowing, cannot swallow pills or eat usual foods. Rates pain at 6/10. Weight 92". Constipation remains well-controlled with XXXX. Stage II wound on coccyx. Dyspnea well-controlled with XXXX regimen, but patient remains bed-bound. Well cared for by son and husband."

Changes to Plan of Care?

- Pain
  - What change to intervention?
  - Do we have new problem here?
- Alteration in bowel?
  - Resolve?
- Skin Integrity
  - New interventions and goals?
- Dyspnea
  - Any changes to goals and interventions?

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One Month Later

SW: Durable power of attorney for health care completed, naming son as healthcare proxy. "Five Wishes" also completed. Spouse says he is doing "OK, considering," and expresses gratitude for son and friends. Son reports feeling irritable all the time, and not sleeping; worrying about what will happen to hisfather when patient dies. Scored 17 on Beck Depression Inventory. Drinking wine during visit.

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Changes to Plan of Care?

- Advance Directives
  - Resolved?
- Difficulty coping
  - Interventions and goals?
- Addiction?
- Placement?

One Month Later

Chaplain: Team RN and social worker report that son has begin expressing resentment over her parent's atheism, worried about their place in heaven. He has strong Christian beliefs.

Changes to Plan of Care?

- Is it time to add a problem?
- What is the first intervention and goal?

IDT Summary

- Remember, the purpose here is to track the patients progress toward achieving desired goals, and make changes.

Sample IDT Summary

Updated Comprehensive Assessment:

Patient has lost ability to swallow, leading to pain above acceptable level (at 8/10) and risk for aspiration. Stage II wound on coccyx not improving with wound care, but not worsening. Advance directives completed. Son scoring at 16 on Beck Depression Inventory, tearful and sleepless, expressing resentment of parent's support group, lacks support group of his own.

Sample IDT Summary

Changes to Plan of Care:

- Pain: change pain med to sublingual morphine xxx due to patient's inability to swallow
- Alteration in bowel: comfort maintained with current regimen

Sample IDT Summary

- Problem: Skin Integrity
- New Problem: Risk of Aspiration
- Goal — Healing of Stage II wound. Change intervention to dressing change once a day, provide teaching to caregivers on turning and dressing changes
- Goal — safety in eating
  Intervention — Speech therapy evaluation, soft foods

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Sample IDT Summary

- Advance Directives: Resolved
- New problem: Difficulty coping, son, as evidenced by tearfulness, sleeplessness, overdrinking

Goal: decreased crying and ability to sleep, lowered score on Beck Depression Inventory (current 17)

- Intervention: Will meet with son 1x weekly to assist in identifying source of sadness, exploring options for care of father in future

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Sample IDT Summary

- New Problem — Resources Needed: As evidenced by possible need for placement for patient's spouse after she dies.
- Goal: Identify options for care and discuss with daughter and husband.
- Intervention: Provide list of assisted living facilities and hired help agencies

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Sample IDT Summary

- New Problem — Spiritual Issues: as evidenced by daughter expressing resentment of parent's beliefs
- Goal: Assist daughter in identifying feelings and triggers
- Intervention: Suggest visit from hospice chaplain

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Sample IDT Summary

- Scope and Visit Frequency for Next 14 Days:
  - RN: 3x week
  - SW: 1x week
  - Chaplain: 1x in two weeks
  - HHA: 3x
  - ST: 2x
  - Vol: 1x week

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Data Captured

- Pain
- Weight
- Distance ambulated comfortably
- Frequency of bowel movements
- Level of depression
- Presence of Advance Directives and Final Arrangements
- Wound Stage

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Social Work

Meh

- "Provided support"
- "Caregiver depressed"

Better

- "Assisted patient with partializing concerns and identifying areas where she could make decisions"
- "Caregiver scored 4 on Beck Depression Scale, down from 12 at admission"

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Spiritual Care

Meh

- "Patient having spiritual issues"
- "Provided ministry of presence"

Better

- Patient says she feels sad over an incident that occurred 40 years ago, and is "guilty and ashamed"
- Explored with patient her values related to mistakes and forgiveness

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Assessment Tools

TODAY

- Karnofsky
- Palliative Performance Scale
- Visual Analog Scales; “1 through 10”
- Wong-Baker Faces Scale
- Vital Signs
- Wound Staging

FUTURE

- What ever is on the HOPE
- Consistent with HQRP

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So What?

The success of hospice care depends on the ability of the hospice to appropriately identify, carry out and re-evaluate the effectiveness of the care and services provided to the patient and family

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Okay – But How?

- Build upon current processes
  - Evaluate how hospice plans of care are currently developed and documented
  - Assess the effectiveness of current processes
  - Incorporate preparation and anticipation of needs into all aspects of care planning and delivery
  - Educate and reassure team members this is not a barrier to good patient care, but, the facilitation of good patient care

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Mobilize

- Functionality of the IDT
- Understanding of each member's role
- Preparation for IDT
- Placing the patient/family at the center

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Functionality

- Know your patient/family's problems
- *Briefly* discuss events since the last IDT, focus on plans and outcomes
- Discuss anticipated needs and be prepared to implement
- Report responses related to the chosen outcome indicators

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References

- Hospice Fundamentals Guide to Hospice Care
- Medicare Hospice Benefit Manual at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
- State Operations Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf
- HOPE at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/HOPE

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