Hospice Initial & Comprehensive Assessment

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Home Health VNA
Merrimack Valley Hospice
HomeCare, Inc.

The Leaders in Home Health and Hospice Care

Objectives

- The participant will be able to list the required elements to perform a Hospice initial & comprehensive assessment
- The participant will be able to describe the Hospice admission procedure
- The participant will be able to discuss the development of the Plan of Treatment (POT)

Hospice Admission Required Elements

- Physicians orders to admit Hospice services
- Admission package including information about the agency and patients rights
- Referral information
- EMR

Hospice Admission Paper Forms

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

Hospice Admission Procedure

- **Use the Hospice Admission Packet to review:**
  - Information about the agency
  - How to reach the agency
  - How to call the state hotline
  - Agency's admission and discharge policies
  - Patient rights and responsibilities
  - Safety information
  - Emergency information

Discussions for ALL Admissions must include

- Explanation of benefits including medication coverage criteria
- Role of SN, MSW, Chaplain, HCA and Volunteer
- Obtain patient history
- Goals of patient/family
- Explain medications for comfort

Hospice Admission Procedure

- Confirm that there is a physician order for admission to Hospice services
- Call the patient/caregiver to schedule the admission visit, requesting that all third party payer information and medications are available for you to review
- After meeting patient/caregiver, describe your agency and your role

Hospice Admission Procedure

- Gather information about the patient's medical history and current symptoms and problems, assuring patient meets Hospice criteria for terminal diagnosis

- Review history and physical from referral source

418.54 Initial and Comprehensive Assessment

- Initial assessment must be completed by hospice RN within 48 hours of election (unless requested to be sooner)

- Is an overall assessment of the patient/family **immediate needs**

418.54 Initial and Comprehensive Assessment

- The hospice interdisciplinary team must complete the comprehensive assessment within 5 days of election

- Comprehensive assessment is about assessing WHAT the patient needs, not all about WHO completes the assessment

418.54 Comprehensive Assessment

- 418.54(c)
- Must identify the physical, psychosocial emotional and spiritual needs related to the terminal illness that must be addressed in order to promote the patients comfort and dignity throughout the dying process.
- It must take into consideration the following factors:

418.54 Comprehensive Assessment

1. Nature and condition causing admission (why hospice?, why now?)

2. Complications & risk factors that affect care planning

3. Functional status & ability to participate in own care

4. Imminence of death

418.54 Comprehensive Assessment

5. **Severity of symptoms**

6. **Drug (medication) profile – all prescription & OTC and herbal remedies including identification of:**
   - Effectiveness
   - Side effects
   - Actual/potential drug interactions
   - Duplicate drug therapy
   - Associated lab monitoring (relatedness & coverage)

418.54 Comprehensive Assessment

7. Bereavement – an initial assessment of the needs of the patients family and others focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death

8. The need for referrals and further evaluation by appropriate health professionals

418.54 (d) Update to the Comprehensive Assessment

- The update must be accomplished by the interdisciplinary team, in collaboration with the attending as frequently as the patients condition requires but no less frequently than every 15 days

- It must consider changes that have taken place , progress toward desired outcomes, and a reassessment of the patients response to care

418.54 (e) Patient Outcome Measures

- Must include data elements that allow for measurement of outcomes.
- The hospice must measure and document data in the same way for all patients

418.54 (e) Patient Outcome Measures

- The data must be part of the clinical record and documented in a systematic and retrievable way

- Must be used in individual patient's care planning and coordination of services and also for the QAPI program

Hospice Admission Procedure

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

Hospice Admission Procedure

- Provide the patient/family with Hospice Handbook (available in Spanish also)
- Provide Process of Dying booklet if death is imminent or when appropriate

Hospice Admission Procedure

- For full Admission, start visit in MobileWyse, using MVH Integrated Assessment visit reason. The Narrative note and NHPCO Core Measures form will populate the visit as well as the Integrated Assessment. All 3 forms must be completed.

Hospice Admission Procedure

- **Obtain signature on NOE and any other paper forms required**
- **Review and reconcile medications, including all drugs:**
  - Prescribed
  - Over-the-counter
  - "As needed"
  - All routes (e.g., inhaled, topical)
  - Vitamins, minerals, supplements, and herbs
  - Oxygen

Hospice Admission Procedure

- Perform a systematic comprehensive physical assessment
- Assess patient's functional status and safety in the environment
- Ask about the caregiver's status
- Discuss initial plan of care with patient/caregiver and the next steps:
  - Who else will visit
  - Anticipated visit schedule
  - Topics that will be discussed with the physician

Hospice Admission Procedure

- Complete Plan of Care (POC) orders – Go to the POC Creation Wizard to complete the POC orders
- Assure complete documentation of the assessment and POC
- Reiterate before leaving, how to reach the agency and 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

Hospice Admission Calls to Make

- **Primary MD**
  - Confirm terminal prognosis of less than six months
  - Obtain order for Meds – Comfort Kit and Medication to be DC'd
  - Get order for any equipment required (always confirm with Manager any special supplies that may be needed)

Hospice Admission Calls to Make

- Comfort Kit – Call long Term Pharmacy to order
- Equipment – Call HCS
- Care Team – Leave voicemail at 978-552-4050, x310. Inform of admission status, any special needs, and whether or not a visit is needed next day
- Facility patients – Communicate with MSW or case manager to inform of Hospice Admission

Special Instructions for SNF Admission

- Check for/obtain MD order for Hospice
- Make copies of DNR/MOLST, med sheets, HealthCare Proxy and Invocation of Proxy if one exists
- Obtain Verification of Reimbursement (VOR) for SNF only

Special Instructions for SNF Admission

- Complete admit and print the following to leave in chart at SNF:
  - Med list
  - Nursing Assessment
  - Yellow copy of Consent Form
- SNF Chart – Use green tab in front of printed forms and put info sheet for Hospice in front of chart
- HCA frequency in SNF if determined by individual plan of care

MobileWyse Hospice Admissions Fact Sheet

- Review “MobileWyse Hospice Admissions” fact sheet

418.56(b) Plan of Care

- **The plan of care must be written and :**
  - Reflect patient and family goals
  - Include collaboration of the attending physician
  - Include interventions for problems identified throughout the assessment process
  - Include all services necessary for palliation and management of the terminal illness and related conditions.
  - Include a detailed statement of the scope and frequency of services to meet the patient's and family's needs.

418.56 (c) Content of the Plan of Care

- Include measurable outcomes with data collected during the comprehensive assessment and updates
- Include all drugs, treatments, medical supplies and appliances
- Include documentation of the patient's or representative's level of understanding, involvement and agreement with the plan of care in the clinical record

Visit Frequency

- Visit ranges are allowable, but if used, they must have a short interval (1-2 x week ; 2-3 x a month , etc)
- Ranges should not include 0 (zero)
- If the patient consistently requires a visit at the top of the range and PRN visits, then the visit range should be increased in the patient's plan of care
- If PRN visits are included on the patient's plan of care, a reason should be identified for the visit.
- Use of PRN visits should not be a regular occurrence. If PRN visits are used regularly, then assess the need to increase the visit frequency.

418.56 (d) Review of the Plan of Care

Review of the plan of care includes:

- Information from the updated comprehensive assessment including the progress toward achieving specified outcomes and goals.

- Plan of care must be reviewed, revised as necessary and documented as frequently as the patient's condition requires, but no less frequently than every 15 days.

418.56 (d) Review of the Plan of Care

Review of the plan of care includes:

- A revised plan of care notes the progress toward outcomes and goals.
- Focus on patient care planning . What is plan for next 15 days?

  (Typically accomplished at IDT meeting with updates to attending)

What is a Plan of Care (POC)

- The POC/care plan is like a road map for the patient's care
- It includes problems, interventions, and goals to provide consistent care
- It also supports the medical necessity of Hospice services

What is a Plan of Care (POC)

- The POC includes an assessment of the patients needs and identification of the services to be provided
- This includes the management of any pain along with symptom relief

When is the POC established

- The POC must be established and dated before services are provided

When must the POC be reviewed and/or updated

- The POC must be reviewed and updated by the interdisciplinary group (IDG) at least every 15 calendar days
- It should be continually assessed to ensure the care received by the beneficiary meets their current conditions and needs

When must the POC be reviewed and/or updated

- The POC should be updated if the beneficiary conditions improves or deteriorates, or when the level of care changes

- When the POC is revised, it must include information from the patient's updated comprehensive assessment and must note the patient's progress toward the outcomes and goals specified in the POC

Who participates in the IDG reviews of the POC

- The interdisciplinary group or IDG must include, but is not limited to, the Hospice physician, RN, social worker and pastoral or other counselor